

Exhibit Q

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California Legislature

Senate Committee on Business, Professions & Economic Development

Senator
Curren D. Price, Jr.
Chair

Memorandum

To: Boards Subject to Review in 2011-12

BPM '11MAY12 PM12:15

From: Senator Curren D. Price, Jr.

Date: May 10, 2011

Subject: Request for Information and Issues to be Addressed for 2011-12 Oversight Review

This is to inform you that the Senate Committee on Business, Professions and Economic Development (Committee) will begin its oversight review of the following boards in the fall of 2011:

- Acupuncture Board
- Board of Behavioral Sciences
- Chiropractic Board
- Court Reporters Board
- Pharmacy Board
- Physical Therapy Board
- Physician Assistant Committee
- ✓ Podiatric Medicine Board
- Psychology Board

You will receive separately by email a Report Form that should be completed and submitted to the Committee by November 1, 2011. The Report has been significantly revised from the Report used by the Committee in prior years. The revisions are intended to simplify the reporting process for the boards, and focus more clearly on issues of interest to the Committee. The first sections of the Report provide an overview of the board's current regulatory program, and gives pre-formatted tables and charts to be filled in by the board. The latter sections focus on responses by the board to

particular issues that are raised by the Committee or that are raised by the individual board.

We ask that you complete the tables and charts and provide the appropriate statistical information for the fiscal years indicated. In the event that some information may not pertain to your particular board, please note it on your response, but please be sure to include information that is relevant to your activities and programs.

In completing your Report, please note the following sections:

Section 10 – Board Action and Response to Prior Sunset Issues. This should reflect the board's response to each individual issue and recommendation that was raised by the Committee during the prior review of the board.

Section 11 – New Issues. The Committee may have additional issues that the board will have to address during this review. The board also has an opportunity to raise new issues and make recommendations to the Committee within this section. We encourage the board to request a meeting with Committee staff to review possible issues to be addressed within this document for the 2011 review.

Along with the Report Form, you are also being sent a Guide to complete the tables in the Report. Most of the tables may be completed from data in standard reports that the board already receives. If your board does not use the Department's report and data processes, please report information using the definitions given in the Guide.

Each board should submit 15 printed copies of its final Report to the Committee, and also submit an electronic copy to the Committee (you may submit a PDF version, but we also request a MS-Word copy).

Committee staff will be responsible for investigating and analyzing information provided by the board, and then preparing a background paper with issues to be addressed by the board and, when possible, preliminary recommendations for the board and interested parties to consider during our public hearings to be held early in 2012.

We expect to announce the dates for the hearings sometime in December. We would like to request that once the hearing dates are set that the board send out letters of interest (by mail or email) to your mailing list of organizations, groups, or individuals who would be interested in attending the Committee's public hearings.

If you have any questions about the attached documents or the review process, please contact G. V. Ayers or my staff at (916) 651-4104.

Attachments to be sent by email



Karen L. Wrubel, DPM, President
Neil B. Mansdorf, DPM, Vice President
James J. Longobardi, DPM
Kristina M. Dixon, MBA
Edward E. Barnes

Board of Podiatric Medicine



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Sunset Review Report

2011

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7 “State medical boards are the hidden, unactivated levers to
8 reform.”

9 Thomas H. Meikle, Jr., MD, *President*
10 Josiah Macy, Jr. Foundation
11 Address to Federation of State Medical Boards’ Annual
12 Meeting, 1992
13
14
15

16 “Throughout the western world, medical licensure and
17 discipline authorities are . . . are being compelled to face a
18 paradigm shift of major significance -- from a system
19 grounded in self-regulation by the medical profession itself to
20 one based on protecting the public in accord with its
21 expressed interests. . . . In the public protection paradigm,
22 medical licensure authorities are public, not professional,
23 bodies focused on public protection.”

24
25 Mark R. Yessian, PhD
26 “From Self-Regulation to Protection”
27 *Federation Bulletin*, Vol 81, No 3 1994
28 Federation of State Medical Boards
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CALIFORNIA BOARD OF PODIATRIC MEDICINE

BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM

As of November 1, 2011

Section 1 –

Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.¹ Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

The California Board of Podiatric Medicine (BPM) licenses and regulates Doctors of Podiatric Medicine (DPMs). Though functioning semi-independently as other boards within the Department of Consumer Affairs (DCA), BPM is part of the Medical Board of California (B&P Code §2460) and it is MBC that officially issues licenses to this small specialty group of about 2,000 independent practitioners upon the “recommendation” of BPM (B&P §2486).

DPMs have been licensed by MBC since the 1920s, and the Legislature created the separate podiatric medical entity within MBC in 1957.

The Podiatric Medicine Practice Act is Article 22 of Chapter 5 (Medical Practice Act) of Division 2 (Healing Arts) of the Business and Professions Code (B&P Code). In brief, DPMs are independent practitioners of medicine diagnosing and treating conditions affecting the lower extremity (foot, ankle, and muscles and tendons of the leg governing their functions). In addition, DPMs are authorized by Section 2472 to perform as *assistant* surgeons in any surgical procedure, and they commonly are called upon to do so.

While it is unprofessional conduct for all doctors to practice outside their area of competence, the scope of practice itself in Section 2472 is defined as indicated above. Also noteworthy is that BPM is the only doctor-licensing board in the nation to have implemented a Continuing Competence program over and above continuing education. Since proposed by BPM and enacted in our first Sunset Review in 1998, consumer complaints have decreased by more than 50 percent.

The Continuing Competence program (B&P §2496) succeeded due to the profession’s embracing it as a higher standard of its own, i.e., a mark of professionalism. It is the cornerstone for BPM’s goal of *preventing* patient harm.

Article 12 (Enforcement) is another important and applicable portion of the Medical Practice Act. BPM was the first State agency to support the “Presley bills” sponsored by the Center for Public Interest Law (CPIL). Beginning with SB 2375 of 1990, these moved physician discipline into closer step with public expectations.

1 Upon leaving the Legislature, Senator Presley accepted an appointment to BPM and transmitted our 1997
2 *Sunset Review Report* as BPM President. The recommendations in that report led to enactment of the
3 Continuing Competence program, the sunset of BPM's diversion program, and other reforms.

4
5 Mark Yessian argued against the grain in "Medical Licensure Authorities in an Age of Rising Consumerism,"
6 [*Federation Bulletin*, Vol 81, No 3 1994, Federation of State Medical Boards], "In the public protection
7 paradigm, medical licensure authorities are public, not professional bodies."

8
9 The State Medical Board and BPM *are not physicians' organizations* but government agencies that license
10 MDs and DPMs and are primarily accountable to the public, functioning properly within a public administration
11 framework.

12
13 BPM's Board Members--licensee and lay--are all professional and all represent the public. Under law, their
14 responsibilities are identical, and fully equal. This is reflected in BPM's organizational culture.

15
16 BPM's *Strategic Plan* emphasizes:

17
18 2.3 Represent the public

- 19
20 ☐ Maintain BPM culture that licensee and lay Board Members are equal
21 ☐ Maintain BPM culture that licensee and lay Board Members have same statutory role
22 ☐ Maintain BPM culture that licensee and lay Board Members all represent the public at large

23
24 http://www.bpm.ca.gov/about_us/spweb.shtml
25

26 The mission of the Board is public protection. For two decades, BPM's letterhead has carried the statement
27 from B&P §101.6 that "Boards are established to protect the people of California." BPM strives to avoid
28 diversions of its challenged, limited resources from this statutory licensing and enforcement regulatory
29 responsibility that no one else performs.

30
31 Beginning in the early 1990s, BPM cut every other area of its budget to emphasize public safety through careful
32 licensing and rigorous enforcement. This has paid off. Higher licensing standards, primary source verification,
33 continuing competence, and enforcement actions gained attention of providers and contributed to better medical
34 care for Californians. And in the past four fiscal years, almost 70 percent of BPM expenditures were for
35 enforcement (Table 5).

36
37 BPM's Board Members have worked to raise expectations. The question is not whether MBC or BPM are the
38 best boards in the country--a low bar--but whether we meet the standards Californians deserve.

39
40 BPM's *Strategic Plans* over the past two decades sought to elevate competency levels, reduce medical error,
41 and cut costly enforcement expenditures through responsible licensing and prevention of patient harm rather
42 than just responding to it after the fact.

43
44 "Boards have broad powers to shape the medical profession. For the most part, they do not fully exercise these
45 powers. . . . of . . . enhancing the licensing process as a means of preventing unfit, incompetent physicians from
46 practicing in the first place," said Thomas H. Meikle, Jr., MD, in his President's Statement, *1991 Annual*
47 *Report*, Josiah Macy, Jr. Foundation.

1 With the emphasis given enforcement since the 1990s, California might focus more on licensing as well. BPM
2 was in the enforcement forefront in the 1990s. It initiated the much resisted, still-instrumental Medical Board
3 Enforcement Matrix report to enhance accountability and the quality of data for management and reporting
4 purposes. BPM was the first state agency to support the Presley bills to reform physician discipline, and the
5 first of the MBC “affiliated” health board to hire a full-time Enforcement Coordinator.

6
7 But for licensing boards, good licensing is essential as well. Shortchanging licensing, relying on catching up
8 with dangerous doctors through enforcement -- eventually -- after much harm has been done, raises public
9 policy questions.

10
11 BPM’s licensing initiatives, unique in California, include annual review and approval of all California-based
12 podiatric graduate medical education (GME) residency programs. The Board requires a Resident’s License for
13 all GME participants, and requires two-years of GME rather than just one as required for other doctors. BPM
14 wrote primary source verification of licensing credentials--the unwritten gold standard everywhere--into the
15 law, Article 22 (Podiatric Medicine). And BPM is the only doctor-licensing board in the country to implement a
16 Continuing Competence program, long recommended in the medical licensing literature. Each licensee must
17 meet at least one peer-reviewed indicator of continuing competence at each two-year renewal.

18
19 In sum, BPM fought for stronger enforcement in the 1990s. The lasting reputation contributed to higher
20 standards among practitioners.

22
24 With the first decade of the 21st Century, aided by the 1997-98 and
26 2001-02 Sunset Reviews, BPM advanced licensing reforms. The
28 Continuing Competence program in particular has contributed to the
30 long-term longitudinal decline in complaints. Since it became law in
32 1999, complaints on DPMs filed with MBC Central Complaints have
34 now fallen by two-thirds.

36
38 BPM’s signature reforms include:

- 40
42 ☐ **Primary Source Verification**--no waivers, no exceptions
44 ☐ **Continuing Competence**--implemented pursuant to first Sunset
46 Review
48 ☐ **Diversion**--sunsetting pursuant to first Sunset Review
49 ☐ **Information Disclosure**--overrode former Director’s veto to implement DCA *Recommended Minimum*
50 *Standards for Consumer Complaint Disclosure* (i.e., when “complaint will be referred for legal action”)
51

52 In this new decade, one focus might be the “rare collaboration” reported on the June 27, 2011 *American*
53 *Medical News* -- the California Podiatric Medical Association-California Medical Association-California
54 Orthopaedic Association task force on podiatric medical training:

55
56 <http://www.ama-assn.org/amednews/2011/06/27/prl20627.htm>
57

58 “The CMA is excited to be part of “this unprecedented partnership,” said Dustin Corcoran, CEO of the
59 medical association.”The licensure requirements of podiatrists have increased in California in recent
60 years, and the time has come to evaluate their training programs in this context.”
61

62 BPM has been part of this, co-sponsoring the 1993 “Medio-Nelson Report,” *Report on the General Medical and*
63 *Surgical Components of Podiatric Residency Training in California: A Report to the Medical Board of*

**BPM Revocations & Surrenders
During Prosecution**

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1 *California and the Board of Podiatric Medicine in California*, by distinguished medical educators Franklin J.
2 Medio, Ph.D. and Thomas L. Nelson, M.D.:

3
4 http://www.bpm.ca.gov/forms_pubs/nelson.pdf
5

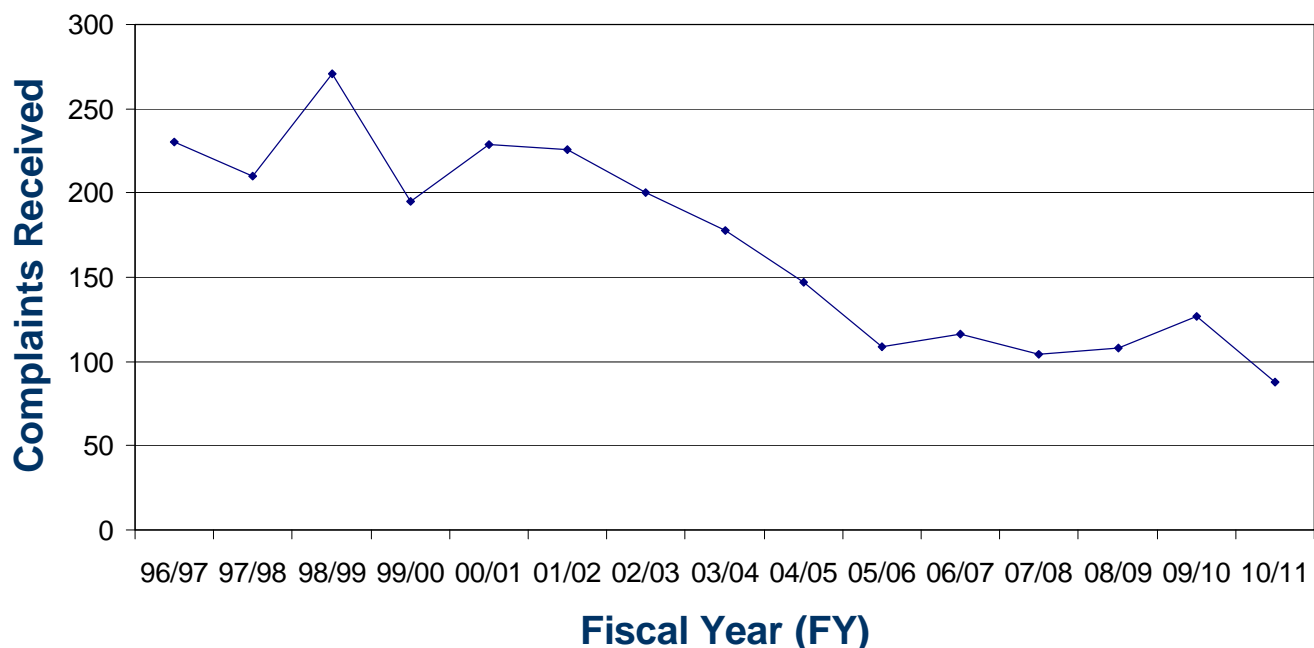
6 BPM helped create the California Liaison Committee and its UC-Access Committees in efforts to
7 implement the Medio-Nelson recommendations. BPM sponsored specific amendments of the B&P Code
8 as discussed herein, and contributed a substantial advisory and technical role in enactment of AB 932,
9 which passed without a single *nay* vote in either House or any committee in 2004, and increased the
10 postgraduate training requirement from one year to two.

11
12 BPM and other licensing boards are mandated to establish entry-level standards. BPM, MBC and other
13 State boards are not certification agencies setting higher standards under the authority of professional
14 bodies like the American Board of Medical Specialties or Council on Podiatric Medical Education. But
15 licensing boards should consider how the professions themselves define what constitutes entry-level
16 education and training. The American Podiatric Medical Association (APMA), has indicated since 1995 that
17 two-years of residency training is the minimum required to achieve entry-level competence.

18
19 Medical education is also continually evolving as medical educators update and improve curriculum and
20 training methods. BPM's work over the past two decades has been in the interests of the profession but
21 designed to improve patient outcomes.

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23 BPM will aid and assist again in the current studies.
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Complaints Received Since Implementation of BPM's Continuing Competence Program (January 1, 1999)



Fiscal Year	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
Complaints Received	230	210	271	195	229	226	200	178	147	109	116	104	108	127	90

"I have given a *lot* of thought to this and brought my staff, faculty (including the former CEO of the American Board of Medical Specialties), our faculty in podiatric medicine, and our colleagues at the National Board of Medical Examiners into the discussion. . . .

"First, you will never know how much we respect the California Board of Podiatric Medicine for being the first Board of any discipline, to our knowledge, to have made a true Maintenance of Competence requirement a legal requirement of licensure. The medical profession is many years away from attaining this enlightenment, if it ever happens at all. We are not aware of any State or country, anywhere in the world, where this is the law. Your Board has done the right thing, and we congratulate you. Your Board will be recounted as heroes in the history books, and I mean this honestly and literally."

--William A. Norcross, M.D., *Clinical Professor of Family Medicine, and Director of the Physician Assessment and Clinical Education (PACE) Program, University of California at San Diego, April 2, 2010*

<http://www.bpm.ca.gov/education/wtsacc.pdf>

1 1. Describe the make-up and functions of each of the board's committees.

2 BPM currently has five committees, which are appointed by the President. BPM's committees serve principally
3 as a means for Board Members (the committee chair and vice chair) to oversee preparation of and present
4 agenda items at Board Meetings. They may also bring items of concern in their area to the attention of the
5 Board and executive officer.

6
7 The Board considers it optimum to keep all seven Board Members involved in all governance areas. In
8 particular, the Board has not created an "Executive Committee" as doing so could tend to limit the input of
9 some Board Members.

10

11 BPM structured its governance model after John Carver's *Boards that Make a Difference* in the early 1990s,
12 and that remains an influence: ". . . an executive committee tends to become the real board within the board,
13 with debilitating effects on holism." [Third Edition, page 233]

14

15 The Board functions as a Board, and the Executive Officer serves and reports to the entire Board, not to one or
16 two officers. The Board's Position Descriptions for President, Vice President and Executive Officer underscore
17 this:

18

19 http://www.bpm.ca.gov/about_us/policies.shtml

20

21 There have been no separate committee meetings since the Licensing and Medical Education Committee met
22 October 7, 2004 to prepare the final "Section 2499.5(k)" exams for doctors licensed prior to 1984, in order to
23 provide them opportunity to obtain the modern scope of practice pursuant to the amendment of Section 2472
24 made by AB 932 of 2004.

25

26 Dr. Wrubel, who was re-elected President for 2011, appointed the current committees February 24, 2010:

27

28 **Public Outreach**

29 Ms. Dixon, *chair*

--external communication & public liaison

staff: Jim Rathlesberger (916-834-2445)

31 **Enforcement**

32 Dr. Mansdorf, *chair*

--enforcement procedures

staff: Bethany DeAngelis (916-263-4324)

34 **Legislative**

35 Ms. Dixon, *chair*

36 Dr. Longobardi, *vice chair*

--legislative liaison

staff: Mischa Matsunami (916-263-0315)

38 **Licensing & Medical Education**

39 Dr. Longobardi, *chair*

--licensing, exams, approval of schools & residencies

staff: Christine Raymond (916-263-2649)

41 **Professional Practice**

42 Dr. Wrubel, *chair*

--guides & advises staff on practice matters

staff: Jim Rathlesberger (916-834-2445)

43

44 The committees are two-Member bodies, but since February 24, 2010 the terms/grace years of two former
45 Board Members expired so that only the Legislative Committee retains two Members. Following the election
46 of new officers September 23, the President-elect for 2012 will appoint new committees with the Board's
47 current membership. Mr. Barnes was appointed by Senate Rules effective June 15, 2011 and there are two
48 vacant Gubernatorial positions (one licensee, one lay) that could be filled by that time.

Table 1a. Attendance (Last Sunset Review 2001)**Jon H. Williams, DPM**

Date Appointed:	Original Appointment 5/7/1993 Re-Appointed 9/18/1996 – 6/1/2001		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	N
	5/4/2001	Millbrae, CA	Y
	Grace Year Term expired 6/1/2001		

Elaine S. Davis, DPM

Date Appointed:	Original Appointment 4/4/1994 Re-Appointed 12/15/1997 – 6/1/2002		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	Y
	Grace Year Term expired 6/1/2002		

Iva P. Greene, MA

Date Appointed:	Original Appointment 11/21/1994 Re-Appointed 11/2/1999 – 6/1/2002		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	N
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	N
	5/3/2002	Millbrae, CA	Y
	11/8/2002	San Diego, CA	Y
	Term expired 6/1/2002		

Kenneth K. Phillips, Jr., DPM

Date Appointed:	12/15/1997 – 6/1/2001		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	N

	5/4/2001	Millbrae, CA	Y
Grace Year Term expired 6/1/2001			
Paul J. Califano, DPM			
Date Appointed:	1/1/1999 – 6/1/2002		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	Y
	Term expired 6/1/2002		
Joseph M. Girard, MBA, JD			
Date Appointed:	1/1/1999 – 6/1/2002		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	N
	Term expired 6/1/2002		
Anne M. Kronenberg, MPA			
Date Appointed:	8/18/1999 – 6/1/2003		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	Y
	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
	Term expired 6/1/2003		
Brad Naylor, DPM			

Date Appointed:	5/23/2002 – 6/1/2005		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	Grace Year Term expired 6/1/2005		
Phyllis Weinstein, DPM			
Date Appointed:	5/23/2002 – 6/1/2005		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	N
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	Grace Year Term expired 6/1/2005		
Raymond Cheng, AIA			
Date Appointed:	Original Appointment 10/31/2002 – 6/1/2006 Re-Appointed 5/16/2007 – 6/1/2011		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	N
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y

	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
	2/29/2008	Ontario, CA	Y
Board Meeting 2008	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
	2/6/2009	San Diego, CA	Y
Board Meeting 2009	6/5/2009	San Francisco, CA	Y
	10/16/2009	Hawthorne, CA	Y
	2/18/2010	Hawthorne, CA	Y
Board Meeting 2010	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	N
	2/11/2011	Sacramento, CA	Y
Board Meeting 2011	Grace Year Term expires 6/1/2011		

James LaRose, DPM

Date Appointed:	Original Appointment 10/31/2002 – 6/1/2005 Grace Year Term expired 6/1/2006 Re-Appointed 7/31/2006 – 6/1/2010		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	N
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y

	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	Term expired 6/1/2010		
Robert Mohr, DPM			
Date Appointed:	10/31/2002 – 6/1/2007		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
	1/26/2004	Oakland, CA	Y
Board Meeting 2004	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
	1/28/2005	Sacramento, CA	Y
Board Meeting 2005	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
	3/3/2006	San Diego, CA	Y
Board Meeting 2006	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
	2/2/2007	Irvine, CA	Y
Board Meeting 2007	Grace Year Term expired 6/1/2007		
Elizabeth Graddy, PhD			
Date Appointed:	2/4/2003 -6/1/2007		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	N
	9/30/2005	Millbrae, CA	N
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
	Grace Year Term expired 6/1/2007		

Aleida Gerena-Rios, MBA			
Date Appointed:	Original Appointment 8/25/2004 – 6/1/2007 Re-Appointed 6/1/2007 – 6/1/2011		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2004	10/8/2004	San Diego, CA	N
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	N
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y
	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	N
	10/15/2010	Los Angeles, CA	N
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	Grace Year Term exp 6/1/2011		
Hienvu Nguyen, DPM			
Date Appointed:	8/16/2005 – 6/1/2009		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2005	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y

		Term expired 6/1/2009	
Michael Levi, DPM			
Date Appointed:	9/28/2005 – 6/1/2009		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2005	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	Term expired 6/1/2009		
Karen Wrubel, DPM			
Date Appointed:	Original Appointment 5/16/2007 – 6/1/2010 Re-Appointed 12/21/2010 - 6/1/2014		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2007	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y
	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD
Paul Koretz			

Date Appointed:	6/15/2007 – 6/1/2010*		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2007	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	N
	6/5/2009	San Francisco, CA	N
*8/22/2009 resigned position on Board due to time & other conflicts			

Neil Mansdorf, DPM

Date Appointed:	1/26/2010 – 6/1/2012		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

James Longobardi, DPM

Date Appointed:	1/26/2010 – 6/1/2012		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

Kristina Dixon, MBA

Date Appointed:	Original Appointment 2/2/2010 – 6/1/2010 Re-Appointed 11/15/2010 – 6/1/2014		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled

	9/23/2011	Los Angeles, CA	TBD
Edward E. Barnes			
Date Appointed:	6/15/2011 – 6/1/2015		
Meeting Type	Meeting Date	Meeting Location	Attended?
Board Meeting 2011	2/11/2011	Sacramento, CA	Not on Board
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

1 The Board currently has two vacancies. One four-term term began in 2009 and the other in 2010:

2

Table 1b. Board/Committee Member Roster (Last 4 FY 07/08 – 10/11)					
Member Name (Include Vacancies)	Date First Appointed	Date Re- appointed	Date Term Expires	Appointing Authority	Type (public or professional)
Karen Wrubel	5/16/2007	12/21/2010	6/1/2014	Governor	Licensee
Neil Mansdorf	1/26/2010		6/1/2012	Governor	Licensee
James Longobardi	1/26/2010		6/1/2012	Governor	Licensee
Kristina Dixon	2/2/2010	11/15/2010	6/1/2014	Speaker of Assembly	Lay
Edward E. Barnes	6/15/2011		6/1/2015	Senate Rules	Lay
- Vacant -			6/1/2014	Governor	Lay
- Vacant -			6/1/2013	Governor	Licensee
Raymond Cheng	10/31/2002	5/16/2007	6/1/2010 Grace term exp 6/1/2011	Governor	Lay
Aleida Gerena-Rios	8/25/2004	6/1/2007	6/1/2011	Senate	Lay
James LaRose	5/23/2002	7/31/2006	6/1/2009 Grace term exp 6/1/2010	Governor	Licensee
Hienvu Nguyen	8/16/2005		6/1/2008	Governor	Licensee
Michael Levi	9/28/2008		6/1/2008	Governor	Licensee
Paul Koretz	6/15/2007		8/22/2009*	Speaker of Assembly	Lay
Elizabeth Graddy	2/4/2003		6/1/2006 Grace term exp 6/1/2007	Speaker of Assembly	Lay
Robert Mohr	10/31/2002		6/1/2006 Grace term exp 6/1/2007	Governor	Licensee
* Paul Koretz resigned his position as Board Member on 8/22/2009 to pursue elected office.					

3

4

5 2. In the past four years, was the board unable to hold any meetings due to lack of quorum?

6 No.

7

8 3. Describe any major changes to the board since the last Sunset Review, including:

- 9 • Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)

10 Along with the Medical and other boards, BPM moved from the 1420 Howe Avenue complex to 2005
11 Evergreen Street in 2008.

12

13 Since the 2002 Sunset Review, Paul Califano, DPM was succeeded as Board President sequentially by Anne
14 Kronenberg, MPA, Brad Naylor, DPM, Raymond Cheng, AIA, James LaRose, DPM, Hienvu Nguyen, DPM,
15 Aleida Gerena-Rios, MBA, Michael Levi, DPM and Karen Wrubel, DPM.

1 During her presidency, Anne Kronenberg, MPA hosted a two-day Strategic Planning session at the San
2 Francisco Health Commission October 3 and 4, 2003 facilitated by Travis McCann, chief of DCA Training and
3 Development Services. This Strategic Plan, not strikingly different than previous strategic plans in essential
4 substance, has been updated annually by the Board.
5

- 6 • All legislation sponsored by the board and affecting the board

7
8 SB 1955 [Joint Committee, Statutes of 2002, Chapter 1150] extended BPM sunset date to July 1, 2007. It in
9 effect sunsetted the Board's oral clinical State licensing exam and required Part III of the national written exam
10 instead. It extended the \$900 renewal fee from January 1, 2004 to January 1, 2006. In addition, it refined
11 BPM's Continuing Competence program, initiated at the Board's recommendation in the 1997-98 sunset
12 review. This landmark initiative, recommended in the medical licensing literature for decades, remains the first
13 and still the only such program implemented by any doctor-licensing board in the U.S. It has led to a steady
14 longitudinal 50 percent decline in patient complaints, helping to reduce medical error and patient harm. One of
15 several signature BPM programs, it is at the core of BPM's Strategic Plan to *prevent* patient harm rather than
16 just respond to it after the fact.
17

18 AB 1777 [Assembly B&P, Statutes of 2003, Chapter 586] included BPM's recommendation for *statutory*
19 primary source verification of DPM licensing requirements. Another unique BPM reform contributing to
20 professional excellence and quality care, writing the unwritten national "Gold Standard" of all professional
21 licensing into BPM's licensing law created a firewall against any pressures for waivers and exceptions.
22

23 SB 1077 [Senate B&P, Statutes of 2003, Chapter 607], a committee bill with Medical Board provisions and
24 conforming language for BPM regarding fictitious name permits and retired licenses.
25

26 AB 932 [Koretz, Statutes of 2004, Chapter 88] updated antiquated, discriminatory practice act language, and
27 authorized DPMs to be assistant surgeons in any surgical procedure--not limited to foot and ankle. It also
28 upped the graduate medical education licensing requirement from one to two years, the highest for any doctor
29 profession in the State, in conformity with the medical education literature. Sponsored by the California
30 Podiatric Medical Association (CPMA), and passing without a single nay vote in either House or any
31 committee, AB 932 was influenced by BPM's development of the Federation of Podiatric Medical Boards'
32 (FPMB) *Model Law*.
33

34 SB 1549 [Figueroa, Statutes of 2004, Chapter 691] removed the sunset clause on BPM's \$900 biennial renewal
35 fee. This, together with proposals herein to modernize the remainder of the fee schedule (Section 11), was
36 designed to stabilize the Board's fund condition. The renewal fee, previously \$800, had been increased to \$900
37 temporarily by AB 1252 [Wildman, Statutes of 1999, Chapter 977].
38

39 SB 1913 [Senate B&P, Statutes of 2004, Chapter 695] added B&P Code §2475.1 as recommended by the Board
40 to require passage of the National Board of Podiatric Medical Examiners exam Parts I and II prior to BPM's
41 issuance of a Resident's license, for a candidate to participate in a California-based graduate medical education
42 residency program.
43

44 SB 231 [Figueroa, Statutes of 2005, Chapter 674] fine-tuned MBC-BPM enforcement procedures including
45 initiation of "vertical enforcement," providing for co-assignment of investigations to MBC investigators and
46 Deputy Attorneys General (DAGs) from the outset so that investigations benefit from AG input.
47

1 SB 232 [Figueroa, Statutes of 2005, Chapter 675] extended sunset date for BPM and several other boards from
2 July 1, 2007 to July 1, 2008.

3 SB 1111 [Senate B,P&ED, Statutes of 2005, Chapter 621] enacted BPM-sponsored housekeeping provisions
4 recommended in BPM's 2005 Sunset Review Report (submitted prior to the extension of the 2007 sunset date).

5 SB 1438 [Figueroa, Statutes of 2006, Chapter 223] updated and clarified language in Article 11 (Professional
6 Reporting) of the B&P Code regarding reporting requirements to the Medical Board about MD or DPM
7 misconduct. Recommendations from BPM's Strategic Plan and BPM Counsel George Ritter were included.

8
9 SB 1476 [Figueroa, Statutes of 2006, Chapter 658]. Following submission of BPM's 2006 Sunset Review
10 Report, this bill extended the sunset date to July 1, 2010.

11
12 SB 1048 [Senate B,P&ED, Statutes of 2007, Chapter 588] included a BPM-sponsored provision restoring its
13 hiring authority, which had been inadvertently sunsetted..

14
15 SB 1779 [Senate B,P&ED], extending statutory primary source verification to B&P Sections 2486 and 2488,
16 vetoed by Governor Schwarzenegger September 27, 2008.

17
18 AB 1071 [Emmerson, Statutes of 2009, Chapter 270], extended BPM sunset date to current January 1, 2013.

19
20 SB 819 [Yee, Statutes of 2009, Chapter 308], extended statutory primary source verification to B&P Sections
21 2486 and 2488.

22
23 SB 953 [Walters, Statutes of 2010, Chapter 105] sunsetted Section 2397(d), which excluded DPMs from the
24 Article 17 Good Samaritan exemptions from liability provisions in Chapter 5 (Medicine), Division 2 (Healing
25 Arts) of the B&P Code.

26
27 SB 1111 [Negrete McLeod], the Schwarzenegger Administration's "Consumer Health Care Enforcement Act,"
28 attempted to extend to other health licensing boards measures first enacted for the Medical Board and BPM by
29 the "Presley Bills" sponsored by the Center for Public Interest Law. BPM was the first State agency to support
30 those measures, beginning with SB 2375 of 1990. BPM voted unanimously February 18, 2010 to endorse SB
31 1111, but was the only board listed in support in the committee's bill analysis.

32
33 • All proposed regulations initiated since the board's last sunset review.

34 <http://www.bpm.ca.gov/lawsregs/index.shtml>

35
36 Public Disclosure; Public Retention [1399.698]
37 *Amendment Filed w/Secretary of State: January 31, 2002*
38 *Effective: March 2, 2002*

39
40 Applications, Certificates [1399.660]
41 *Amendment Filed w/Secretary of State January 7, 2003*
42 *Effective: February 6, 2003*

43 Continuing Competence
44 *Filed w/Secretary of State: July 24, 2003*
45 *Effective: August 23, 2003*

1 [Licensing Education and Certification](#)

2 *Filed w/Secretary of State: November 12, 2003*

3 *Effective: December 12, 2003*

4 [Information Disclosure](#)

5 *Filed w/Secretary of State: April 15, 2004*

6 *Effective: May 15, 2004*

7 *Board voted unanimously to override DCA Director's Veto (see Section 6, question 47)*

8 [Advertising \[Fictitious Name Permits\]](#)

9 *Filed w/Secretary of State: March 28, 2005*

10 *Effective: April 27, 2005*

11 [Disciplinary Guidelines](#)

12 *Filed w/Secretary of State: January 5, 2005*

13 *Effective: February 4, 2006*

14 [Board of Podiatric Medicine Manual of Disciplinary Guidelines With Model Disciplinary Orders](#)

15 [Waiver of Requirement](#)

16 *Filed w/Secretary of State: October 4, 2007*

17 *Effective: November 3, 2007*

18 [Applications, Certificates](#)

19 *Filed w/Secretary of State: April 18, 2008*

20 *Effective: May 17, 2008*

21 [Citations and Fines - Contest of Citations](#)

22 *Filed w/Secretary of State: May 16, 2008*

23 *Effective: June 15, 2008*

24 [Review of National Board Applications; Processing Time \[1399.664 Repealed\]](#)

25 *Change without regulatory effect filed 6-11-08*

26 [Retroactive Fingerprinting](#)

27 *Filed w/Secretary of State: September 16, 2009*

28 *Effective: October 16, 2009*

29 Notice to Consumers,

30 http://www.bpm.ca.gov/lawsregs/prop_regs.shtml

31 http://www.bpm.ca.gov/lawsregs/fsr_1399_730.pdf

32 *Vetoed by DCA Director July 30, 2010*

33

34 4. Describe any major studies conducted by the board.

35 None.

36

37 BPM has not conducted formal studies itself since the last review. It continues to review the literature and also
38 recommends a centralized departmental office for management and policy analysis supported by special fund
39 pro rata. Such a professionally-staffed office (MPAs, MBAs, economists, *et cet*) could form collaborative
40 linkages with the graduate public administration university programs in Sacramento.

The Board did sponsor a focus group in 2008 as recommending by the Department in conjunction with adopting its Section 1399.660 (c) regulation shown below on equivalent exams. The focus group unanimously supported the Board's regulation, now in effect:

http://www.bpm.ca.gov/forms_pubs/focus_group_rpmt.shtml

http://www.bpm.ca.gov/forms_pubs/focus_group_rpmt.pdf

<http://www.bpm.ca.gov/lawsregs/bpmregs.shtml>

1399.660. Applications, Certificates.

(a) Applications for certificates to practice podiatric medicine and the form and endorsement of such certificates are subject to and administered according to the provisions of Article 2 (Sections 1307, 1308, 1309), Article 9 (Sections 1331-1332) and Article 10 (Section 1335), of the Medical Practice Regulations (Division 13, Chapter 1).

(b) The parts of the examination administered by the National Board of Podiatric Medical Examiners required by the board pursuant to Section 2486(b) of the Code are Parts I, II and III.

(c) Pursuant to Sections 2475.1, 2486 and 2488 of the Code, the board recognizes the respective, corresponding sections of examinations of the United States Medical Licensing Examination and the National Board of Osteopathic Medical Examiners as equivalent in content to those administered by the National Board of Podiatric Medical Examiners.

5. List the status of all national associations to which the board belongs.

Federation of Podiatric Medical Boards (FPMB)

- Does the board's membership include voting privileges?
Yes, at Annual Meeting (prevented from attending by travel restrictions).
- List committees, workshops, working groups, task forces, etc., on which board participates.
None.
- How many meetings did board representative(s) attend? When and where?
Last FPMB meeting attended was August 22, 2004 in Boston. One attendee (BPM executive officer).
- If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?
BPM has a DCA contract with the National Board of Podiatric Medicine Examiners (NBPME), which develops, scores, analyzes and administers the national licensing exam, the American Podiatric Medical Licensing Examination (APMLE) Parts I, II and III. The Board monitors and communicates with NBPME and others but is not directly involved in NBPME procedures. NBPME changed the name of the exam to APMLE this year. It was previously known as NBPME Parts I, II, and III.

Section 2 – Performance Measures and Customer Satisfaction Surveys

6. Provide each quarterly and annual performance measure report as published on the DCA website
Please see Appendix G.

7. Provide results for each question in the customer satisfaction survey broken down by fiscal year.
Discuss the results of the customer satisfaction surveys.

The Medical Board performs customer satisfaction surveys of consumers who have filed complaints against doctors. BPM inquired about this in 2009 and was informed by a Central Complaint Unit Manager that “Podiatry is not included, just P&S,” i.e., it only surveys complainants against MDs and not those who file DPM complaints.

However, as MBC Central Complaint and Investigation staffs handle MD and DPM cases identically, it is reasonable to expect consumer satisfaction is approximately the same regardless of the doctor’s degree.

As these are surveys of satisfaction with Medical Board staff, BPM defers to MBC to conduct them.

BPM has a *Share Comments* tab in its Home Page:

<https://app.dca.ca.gov/bpm/comments.asp>

as well as a *File a Complaint about the BPM* in its Consumer tab:

http://www.dca.ca.gov/online_services/complaints/citizen_complaint.shtml

Only a couple comments have been received from these links over the past several years.

Since the 1990s, MBC has significantly improved Central Complaint Unit communication with patients throughout the process. BPM is also fortunate that the MBC Enforcement Chief has assigned BPM cases to Consumer Service Representatives who are among the very best. Ian McGlone, BPM’s current CSR, is a hidden asset not appearing on BPM’s organizational chart.

Very few complainants contact BPM HQs staff directly, but BPM’s executive officer has always advised staff to let him speak directly with dissatisfied callers. As MBC has reported, unsatisfactory results are not always the result of unprofessional conduct as defined in the B&P Code, there is not always clear and convincing evidence, and sometimes the matter is not even within MBC jurisdiction, but taking time to listen and discuss often go a long way towards satisfying a person that they are being respected and listened to.

Section 3 – Fiscal and Staff

Fiscal Issues

8. Describe the board's current reserve level, spending, and if a statutory reserve level exists.

Following standard management practices, DCA projects full budget expenditure. With that assumption, BPM's reserve is shown to decline. However, BPM manages its budget so as to always contain yearly spending under full expenditure authority.

A statutory reserve level does not exist. The Board seeks to maintain a fund balance of at least three months. The Board considers this prudent given the small size of the budget and the potential for unpredictable, volatile and somewhat uncontrollable spikes in enforcement costs. It is crucial that BPM maintain a reserve in order to be prepared, for such events as the 25 lawsuits filed against BPM by one attorney several years ago. All were dismissed, but the costs of AG defense were considerable. Even then, however, BPM managed to stay just under budget, and withstood the effort to force the Board's hand.

9. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

The Board has not submitted any BCPs in the past four fiscal years.

10. Describe if/when deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes anticipated by the board.

BPM and the DCA Budget Office recommend updating the schedule of service fees as indicated in this report to match costs that have increased over the couple decades since the fees were set. These were proposed in conjunction with the \$900 biennial renewal fee already enacted, to complement that fee in order to recover full costs of service and fully stabilize the fund condition.

Table 2. Budget Change Proposals (BCPs) -- NONE

BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	\$ Requested	\$ Approved	\$ Requested	\$ Approved
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 3. Fee Schedule and Revenue

Fee	Current Fee Amount	Statutory Limit	FY 2007/08 Revenue	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	% of Total Revenue
Resident's License	60	60	2,100	3,180	2,460	2,400	0.27%
Duplicate License	40	40	0	0	0	0	0.00%
Duplicate Renewal Receipt	40	40	1,000	880	1,080	1,200	0.14%
Letter of Good Standing	30	30	1,080	1,350	1,440	1,470	0.17%
CME Course Approval	100	100	200	100	500	200	0.02%
Exam Appeal	25	25	0	0	25	0	0.00%
Citation Fee	VAR						0.00%
Application Fee	20	20	1,300	1,360	1,400	1,340	0.15%
Fictitious Name Permit	50	50	1,650	1,450	900	1,500	0.17%
Wall Certificate	100	100	5,100	4,800	5,900	5,600	0.64%
Ankle Certification	50	50	0	0	0	0	0.00%
Oral Exam	700	700	0	0	0	0	0.00%
Ankle Exam	700	700	0	0	2	0	0.00%
Initial License	800	800	39,200	38,400	47,200	44,800	5.11%
Fictitious Name Renewal	40	40	6,720	6,640	6,840	6,960	0.79%
Biennial Renewal	900	900	808,200	808,200	825,300	808,100	92.17%
DPM Delinquent Fee	150	150	900	1800	750	1,650	0.19%
FNP – Delinquent Renewal Fee	20	20	180	260	200	200	0.02%
Penalty Fee	450	450	1,350	1,800	1,350	1,350	0.15%

Table 4. Fund Condition

(Dollars in Thousands)	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Beginning Balance	1,195	1,093	1,037	1,011	859	817
Revenues and Transfers	922	896	905	883	918 (proj)	918 (proj)
Total Revenue	\$2,117	\$1,989	\$1,942	\$1,894	\$1,777	\$1,745
Budget Authority	1,355	1,303	1,272	1,359	1,381	1,408 (est.)
Expenditures	1,038	966	931	1,035	960 (proj)	979 (proj)
Fund Balance	\$1,079	\$1,023	\$1,011	\$859	\$817	\$756
Months in Reserve	13.4	13.2	11.7	10.7	10.0	9.3

1 11. Describe license renewal cycles and history of fee changes in the last 10 years.

2 The Board maintains a biennial license renewal cycle. There have been no fee changes in the last 10 years.
3

4 12. Describe history of general fund loans. When were the loans made? When were payments
5 made? What is the remaining balance?

<u>Loan:</u>	<u>Repayments:</u>	<u>Balance:</u>
FY 1991/92: \$625,000	FY 96/97: \$140,000	\$0
	FY 98/99: \$438,550	
	FY 00/01: \$140,115	

10

11 13. Describe the amounts and percentages of expenditures by program components. Use the
12 attached Table 5a: Expenditures by Program Component Worksheet as the basis for calculating
13 expenditures by program component. Expenditures by each component should be broken out by
14 personnel expenditures and other expenditures.

15 During the past four years, almost 70 percent of the Board's total expenditures were for enforcement-related
16 functions. This is consistent with the Board's mission. Nearly half of the Board's enforcement-related
17 expenditures were for investigation and discipline action by the Department of Justice and the Medical Board of
18 California's investigation units. Other expenditure categories were allocated to the Personnel Services and
19 Operating Expenses & Equipment components based on time and resource estimates.

20

Table 5. Expenditures by Program Component

	FY 2007/08		FY 2008/09		FY 2009/10		FY 2010/11	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	244,730	497,341	242,243	448,620	231,382	466,266	240,968	545,716
Examination	0	15,054	0	4,928	0	5,456	0	3,140
Licensing	133,489	89,638	132,133	74,088	126,209	65,813	131,437	70,984
Diversion (if applicable)								
Administration	66,745	43,119	66,066	35,501	63,104	31,309	65,718	34,248
TOTALS	\$444,694	\$645,152	\$440,442	\$563,137	\$420,695	\$ 568,844	\$438,123	\$654,088

21

22

1 Staffing Issues

2
3 14. Describe any staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff
4 turnover, recruitment and retention efforts, succession planning.

5 BPM has a staff of five (5) with no vacancies. In addition to the exempt executive officer, BPM has an office
6 assistant, two associate government program analysts (one Administrative Analyst, one Enforcement
7 Coordinator) and one staff services analyst (Licensing Coordinator). There has been limited turnover. BPM's
8 previous enforcement coordinator served 17 years, and the administrative analyst is currently in his second
9 round of service with BPM in that position. BPM attempted unsuccessfully to upgrade the previous
10 enforcement coordinator to a staff services manager. Upon her leaving for a career opportunity elsewhere after
11 17 years, BPM moved its licensing coordinator into the enforcement job after an open recruitment, and hired an
12 experienced licensing professional from a larger board for the licensing coordinator role. Following the last
13 sunset review, BPM's office technician left for a promotion just before a hiring freeze. Vacant for more than
14 six months, the position was abolished. BPM struggled for a couple years to win support for an exemption from
15 the freeze in order to reestablish and fill this position.

16
17 Through the utilization, paid for from BPM's budget, of shared services from the Department, Medical Board,
18 Attorney General and Office of Administrative Hearings, BPM functions efficiently with a small HQs staff.
19 Dedicated and assigned staff in the Medical Board's Central Complaint Unit, Discipline Coordination Unit, and
20 investigating field offices flesh out the staffing, as do the two corps of BPM medical consultants and expert
21 witnesses. All of the DPM consultants and experts are active practitioners who work for BPM on an hourly
22 basis as cases are assigned.

23
24 15. Describe the board's staff development efforts and how much is spent annually on staff
25 development. Provide year-end organizational charts for the last four fiscal years.

26 BPM's Licensing, Enforcement and Administrative staff have participated in a number of training courses to
27 ensure that the Board's consumer and licensee populations continue receiving exceptional service in a manner
28 consistent with governmental policies and regulations. A large majority of these training opportunities were
29 offered by DCA's Strategic Organization, Leadership and Individual Develop (SOLID) program at no cost to
30 the Board.

31
32 Please see Appendix B for the Board's year-end organizational charts.

FY	Cost	Staff	Course Title	Course Description
10/11	\$375	Enforcement	National Certified Investigator/Inspector Training	Review of interviewing techniques, report writing, administrative proceedings, and principles of administrative law
	N/C	Licensing	Procedures Manual Writing	Tips and tools related to the development of administrative procedures
	N/C	Enforcement	DCA Enforcement Academy	5-day comprehensive overview of the enforcement process.
	N/C	Enforcement/ Administration	Delegated Contracts	Requirements for Expert Consultant contracts

	N/C	Executive	Improving Enforcement and Board Governance	DCA Board Member and Advisory Committee Member Training
	N/C	Executive	DCA Board Member Orientation Training	Roles and responsibilities of Board Members
	N/C	Enforcement/ Executive	BPM Podiatric Medical Consultant Training	Enforcement training
	N/C	Enforcement/ Executive	BPM Expert Review Training	Enforcement training
	N/C	All	DCA Sexual Harassment Prevention Training	Sexual harassment prevention policies
	N/C	Licensing	Completed Staff Work	Analytical processes used to identify and present solutions
	N/C	Administrative	Records Retention Training	Retention guidelines and State Records Center transfer procedures
	N/C	Enforcement	Understanding the Drug Testing Process	Policies and procedures related to the drug testing of licensees as a condition of probation
09/10	N/C	Executive	DCA Investigational Subpoena Training	Subpoena process
	N/C	All	Ethics Orientation for State Officials – Department of Justice	Laws governing acceptable practices as a state official
08/09	\$23	All	DCA Sexual Harassment Prevention Training	Sexual harassment prevention policies
07/08	\$23	All	DCA Sexual Harassment Prevention Training	Sexual harassment prevention policies
	\$100	Enforcement	Sacramento Safety Training	Regulatory investigative techniques
	N/C	Executive	DCA Board Member Orientation Training	Roles and responsibilities of Board Members
	N/C	Executive	DCA Labor Relations Training	Overview of DCA policies and procedures concerning matters related to the Labor Relations program
	N/C	Executive	Understanding the Reasonable Accommodation Process and Effectively Managing Leaves of Absence	Policy overview

Section 4 – Licensing Program

16. What are the board's performance targets/expectations for its licensing program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The Board issues licenses the same day that all licensing requirements are met. License numbers are given out at that time by phone and appear after midnight on the BPM website verifications page. No change or variation in this since the last sunset review. The Licensing Coordinator provides a "personal shopper level of service" to applicants, who meet higher requirements than other doctors (e.g., two years of graduate medical education), pay larger fees, and must comply with statutory primary source verifications. The Licensing Coordinator troubleshoots, expedites and walks the new doctors through the system.

17. Describe any increase or decrease in average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

BPM has not had licensing delays or backlogs in 20 years and foresees none.

BPM has a single application form for resident's licenses for postgraduate training and regular DPM licensure. The average time taken to process a permanent license from application to issuance varies only due to each applicant's fulfilling of the requirements. License numbers are issued the day all requirements are met and will appear online the following day. Applicants may hold off paying the \$900 initial license/certification fee until they are ready to begin practicing.

Most podiatric residents take the Part III exam after completing one or two years of post-graduate training, and then continue in training or seek regular licensure. Since January 1, 2005 [AB 932, Statutes of 2004, Chapter 88], two years of graduate medical education (GME) is required instead of just one. A few residents do not seek the permanent license, planning to practice in another state. GME residency programs are either two or three years in duration.

BPM experienced an increase in processing time in FY 2002-03 due to the conversion to the National Boards Part III exam. NBPME requires applicants to register for the exam 60 days prior to the exam date. Since application to the appropriate state licensing agency is a prerequisite for exam registration, BPM now requires applicants to apply/register for the permanent license 60 days prior to the exam date. Additionally, score reporting is at times delayed slightly as opposed to prior BPM oral exam results, which were available immediately following the examination (mailed Monday following Saturday exam).

BPM's Licensing Coordinator has streamlined the application process. Application forms were simplified. Notarization is no longer required, and the need for multiple photographs was reduced to just one. Application instructions and forms are now available on BPM's website.

Primary source verification has been strengthened, not compromised.

BPM is proposing sunseting of B&P Section 2493(b) under Question 24 below in the Examinations section.

Table 6. Licensee Population

		FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
License Type: DPM (E, EFE – Military ¹)	Active (In-State)	1719	1729	1736	1764
	Out-of-State	151	143	151	145
	Out-of-Country	3	3	3	4
	Delinquent ²	138	139	124	128
License Type: Resident (EL)	Active (In-State)	121	141	137	128
	Out-of-State ³	3	2	9	20
	Out-of-Country ⁴	0	0	0	1
	Delinquent	N/A	N/A	N/A	N/A

¹ Active (In-State) count includes military status EFE licenses.

² Delinquent licenses cancel after three years. B&P Code 2427(b).

³ Podiatric Medical Residents, with out-of-state addresses of record, holding California Resident's Licenses for participation in California-based graduate medical education programs.

⁴ Podiatric Medical Residents, with out-of-country addresses of record, holding California Resident's Licenses for participation in California-based graduate medical education programs.

1

Table 7a. Licensing Data by Type

Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
					Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2008/09	(Exam)	-	-	-	-	-	-	-	-	-
	(License)	23	23	0	47	-	-	-	-	-
FY 2009/10	(Exam)	-	-	-	-	-	-	-	-	-
	(License)	61	61	0	59	-	-	-	-	-
FY 2010/11	(Exam)	-	-	-	-	-	-	-	-	-
	(License)	61	61	0	58	0	0	0	43	-

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data

	FY 2008/09	FY 2009/10	FY 2010/11
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	23	61	61
Initial License/Initial Exam Applications Approved	23	61	61
Initial License/Initial Exam Applications Closed	0	0	0
License Issued	47	59	58
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	-	-	4
Pending Applications (outside of board control)*	-	-	4
Pending Applications (within the board control)*	-	-	0
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE)			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	8
Average Days to Application Approval (incomplete applications)*	-	-	-
Average Days to Application Approval (complete applications)*	-	-	8

* Optional. List if tracked by the board.

2

3 18. How does the board verify information provided by the applicant?

4 The Board has always required "primary source verification." This is intended to prevent falsification of
5 documents or any possibility of hurried licensing without proper credentialing. Under this policy, all licensure
6 documents certifying applicants' education, training, out-of-state licensure, or criminal clearance must be sent
7 directly to the Board from the certifying organization rather than the applicant.

8

1 At BPM's recommendation, AB 1777 [Assembly B&P Committee, Statutes of 2003, Chapter 586] initiated
2 *statutory* primary source verification. Being a national "Gold Standard" in all professional licensing, it seemed
3 appropriate for BPM to take the lead in having this good business practice introduced into the law itself.

4
5 Applicants are required to obtain a state and federal criminal record clearance from the state Department of
6 Justice (DOJ) (including those applying for a Resident's License) and the Federal Bureau of Investigation (for
7 permanent licensure). Applicants must submit fingerprint cards or utilize DOJ's "Live Scan" fingerprinting
8 method. The Live Scan technology allows the applicants to have their fingerprints electronically scanned at
9 numerous locations in California and obtain results in a fraction of the time required for the traditional
10 fingerprint cards. Effective in FY 05/06, all applicants residing in California were required to utilize the Live
11 Scan fingerprinting method for background clearance purposes.

12
13 Eight separate questions on the licensing application require the applicant to disclose under penalty of perjury
14 any disciplinary actions (past or pending), denials, or convictions related to licensing in other states or health
15 care facilities. Applicants are also required to disclose any addictions to controlled substances and any
16 convictions of misdemeanors or felonies.

17
18 Applicants who have been licensed in other states must arrange for their respective licensing agencies to
19 directly submit verification of license status and any disciplinary actions or active investigations to the Board.
20 In addition, applicants must request a disciplinary databank report be submitted directly from the Federation of
21 Podiatric Medical Boards to the BPM.

22
23 When the Board is notified of any adverse information or criminal record, applicants must provide full and
24 complete explanations and certified copies of arrest reports, all applicable court documents, and documentation
25 of rehabilitation, if any. After careful consideration, Board staff may deny the license or endorse a stipulated
26 agreement for a probationary license. Applicants may appeal the decision and request a hearing before an
27 administrative law judge. Stipulations and ALJ proposed decisions go to the Board Members for final review
28 and approval.

29
30 a. What process is used to check prior criminal history information, prior disciplinary actions, or
31 other unlawful acts of the applicant?
32 Fingerprint reports from California Department of Justice and FBI, report from Federation of Podiatric
33 Medical Boards data bank, self-disclosure under penalty of perjury.

34
35 b. Does the board fingerprint all applicants?
36 Yes.

37 c. Have all current licensees been fingerprinted? If not, explain.
38 All applicants since 1964 were fingerprinted. Those licensed prior to 1964 are being fingerprinted upon
39 renewal pursuant to the Board's regulations (Article 12).

40
41 d. Does the board check a national databank?
42 Yes.

43 e. Does the board require primary source documentation?
44 Yes. BPM sponsored legislation writing statutory primary source verification into all licensing
45 requirements. As far as is known, BPM is the only DCA board to have done so, but the gold standard is
46 tarnished if subject to waiver.

1 19. Describe the board's legal requirement and process for out-of-state and out-of-country applicants
2 to obtain licensure.

3 Since the last Sunset Review, BPM sponsored SB 363 [Figueroa, Statutes of 2003, Chapter 874], which created
4 B&P Code §2488 providing for "licensure by credentialing." Section 2488 provides for that for doctors
5 licensed in another State, only one year of graduate medical education is required, rather than two, and only part
6 III rather than parts I, II and III of the National Board exams is required if it has not been taken and passed
7 within 10 years.

8
9 Out-of-country applicants have not been an issue to date because all schools approved by the national Council
10 on Podiatric Medical Education (CPME) are in the U.S. To date there has not been any four-year school in
11 another country, and the podiatric professions abroad have not been on par with that in the U.S. As chiropody
12 and podiatry schools in the United Kingdom continue advancing, this could become a matter for legislative
13 proposals in the future. Podiatric medicine in the UK is approaching U.S. standards in some cases. There has
14 been preliminary, exploratory discussion at the Federation of Podiatric Medical Boards (FPMB) and other
15 professional bodies with U.K. podiatric medical representatives.

16
17 In 2005, California Podiatric Medical Association President T. L. Basso, DPM, FACFAS and other association
18 representatives met with DCA Director Charlene Zettel. In an August 9, 2005 follow-up letter, Dr. Basso
19 wrote:

20
21 Also during our conversation you made a very interesting point regarding boards having the
22 potential for limiting licensees from coming into the state. Having been in practice for over 15
23 years, and having been on the board of the California Podiatric Medical Association for going on
24 eight years now, I have never once come across a single complaint to our Association regarding
25 restriction of trade imposed by the Board of Podiatric Medicine. In my view they have had a
26 consistently very fair and balanced approach to licensing.

27
28 **Continuing Education/Competency Requirements**

29 20. Describe the board's continuing education/competency requirements, if any. Describe any
30 changes made by the board since the last review.

31 Pursuant to B&P §2496, BPM's regulations [CCR Title 16, Division 13.9, Section 1399.669] require 50 hours
32 of continuing medical education (CME) at each two-year renewal. In addition, Section 2496 requires
33 compliance at each renewal with at least one of several peer-reviewed pathways for the Continuing Competence
34 requirement. This was enacted in 1998 through SB 1981 [Greene, Statutes of 1998, Chapter 736] at BPM's
35 recommendation during the Board's first Sunset Review.

36
37 CME remains important, but it is the Continuing Competence requirement that defines the professional culture,
38 of which CME is now a part. BPM proposed the first -- and still only -- Continuing Competency program of any
39 doctor-licensing board in the Nation in its first Sunset Review.

40
41 As BPM recommended in its second Sunset Review, the Continuing Competence program was refined and
42 tightened up by SB 1955 [Joint Committee, Statutes of 2002, Chapter 1150] and follow up Board regulations, as
43 discussed below under Issue #8.

44
45 Section 2496 provides *several peer-reviewed pathways* indicating maintenance of competence, as was
46 recommended in the medical licensing literature on which BPM based its legislation. Since implementation of

1 the program in 1999, there has been a *steady longitudinal decline in complaints of more than 50 percent*. The
2 88 complaints in FY 2010-11 is an all-time low.

3

4 For DPMs not receiving peer review through specialty board certification or health facility privileging, B&P
5 Code §2496 offers the pathway of taking and passing Part III of the National Boards. Some have taken this
6 route, while the law serves as an incentive for many others to maintain hospital privileges and board
7 certifications. Maintenance of skills through life-long learning was exactly the intent of the legislation, which
8 was drafted based on the medical licensing literature, including that of the Federation of State Medical Boards,
9 Pew Health Professions Commission and the American Board of Medical Specialties. Most importantly, the
10 Continuing Competence statute created a new, higher standard that the podiatric medical profession has
11 internalized and made its own.

12

13 It seems clear that Continuing Competence maintains physician competence and prevents patient harm, and
14 could help offset the epidemic of medical error harming patients and the healthcare delivery system.

15

16 **CME alone is insufficient. The Pew Health Professions Commission commented in 1995: "States should**
17 **require each board to develop, implement and evaluate continuing competency requirements to assure**
18 **the continuing competence of regulated health care professionals. . . . The evidence that continuing**
19 **education cannot guarantee continuing competence is sobering."** (*Reforming Health Care Workforce*
20 *Regulation: Policy Considerations for the 21st Century*, Report of the Taskforce on Health Care
21 *Workforce Regulation*, December 1995).

22

23 The Federation of State Medical Boards (FSMB) reported in its January 2005 *News Line* that a Gallup Poll of
24 patients found that "Ninety percent of respondents ranked physicians being periodically re-evaluated on their
25 qualifications as "very important" or "important."

26

27 a. How does the board verify CE or other competency requirements?

28 Self-certification under penalty of perjury at each two-year renewal.

29

30 b. Does the board conduct CE audits on its licensees? Describe the board's policy on CE audits.

31 BPM verifies the continuing competence and education requirements through audits. Audits are conducted
32 on all licensees subject to investigator interviews (due to complaints), as well as through an annual random
33 audit of one percent of licensees.

34

35 The Board's Regulations, §1399.676(b), Audit and Sanctions for Noncompliance, authorize an annual
36 random audit, and BPM considers it an excellent good practice.

37

38 As indicated below in Issue #5 from the 2002 Sunset Review, BPM's annual audit was temporarily
39 interrupted when the Board discontinued its audit contract with the Medical Board due to fiscal challenges.
40 BPM resumed the annual audit in 2004. It had been delayed when BPM lost its only clerical position. The
41 Office Technician (OT) position was abolished after being vacant for six months during a hiring freeze.
42 After three years of concentrated effort, during which time BPM's professional staff was performing the OT
43 duties as well as their own, the Board was finally able to reestablish this position January 1, 2005. The
44 Licensing Coordinator actually resumed performing an annual audit in 2004.

45

46 BPM recruited a new Licensing Coordinator in 2009 when the incumbent transferred elsewhere for
47 promotion. When the Enforcement Coordinator of 17 years did the same in 2011, BPM concluded the

recruitment for that position by moving the Licensing Coordinator into enforcement and hiring from another board to fill the licensing position. These staff changes and the impact of furloughs beginning in February 2009 led to another break in the audits. The new Licensing Coordinator has initiated an audit for 2011.

The annual random audit verifies the self-certification under penalty of perjury in the current renewal period with the Continuing Competence and 50-hour CME requirements. The Licensing Coordinator processes the renewal as indicated by the audit.

c. What are consequences for failing a CE audit?

The doctor cannot be renewed without a waiver granted by the Board (BPM's Regulations: §1399.669(d)), and only one two-year waiver is permitted. If not brought current in next two-year cycle, the license will not be renewed until the deficiency is corrected pursuant to §1399.676(c)--Audit and Sanctions for Noncompliance), and §1399.678(e)--Waiver of Requirement.

d. How many CE audits were conducted in the past four fiscal years? How many fails?

After the hiatus caused by losing its only clerical employee, BPM's Licensing Coordinator resumed the CME/Continuing Competence Audit in 2004:

In FY 2004-05, 20 licenses were audited without any failures indicated in the records.

In FY 2005-06, 20 were audited. All passed except for two receiving waivers (one converting to Retired status and one to Disabled).

In FY 2006-07, 20 were selected. One waiver was granted, and two cancelled.

For FY 2007-08, 23 were selected. 21 passed. One cancelled. One converted to Retired.

In FY 2008-09, a random selection was requested from DCA Information Services, but the audit was not completed due to turnover in the Licensing Coordinator position.

The interruption continued as furloughs strained the ability of BPM's five-person staff to maintain daily licensing and enforcement operations.

BPM's new Licensing Coordinator has initiated a FY 2011-12 Audit.

e. What is the board's course approval policy?

Under BPM's regulations (1399.670--Approved Continuing Education Programs), medically-related courses sponsored by medical and podiatric medical associations and schools are automatically approved. This covers almost all CME taken by DPMs in health facilities and medical conferences such as the Western Foot and Ankle Conference, the pre-eminent podiatric medical CME conference in the country.

f. Who approves CE providers? Who approves CE courses? If the board approves them, what is the board application review process?

BPM's regulations (1399.671--Criteria for Approval of Courses) provide guidance for Board approval of additional programs but this is rarely employed. The Board's Licensing and Medical Education Committee reviews and approves such applications, staffed by the Licensing Coordinator.

g. How many applications for CE providers and CE courses were received? How many were approved?

Since the last review in 2002, there have been 15 CE applications received. All 15 of the providers and courses were approved.

h. Does the board audit CE providers? If so, describe the board's policy and process.

BPM's regulations (1399.674--Withdrawal of Approval) authorize BPM to withdraw approval from providers if indicated. Given the small number of providers approved by the Board, BPM does not audit but does monitor feedback for any action that might be appropriate.

i. Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensees' continuing competence.

Done. In 1998, BPM became the first and still only doctor-licensing Board in the country to implement Continuing Competence. CME remains important but Continuing Competence is more so, and is BPM's focal point rather than CME.

Flashback--April 21, 1992--Senate Business & Professions Chairman Dan Boatwright commented in "an impromptu appearance" before another board:

He reminded the committee members that the only function that the boards have is to serve the consumer. He reiterated the fact that the only function of the committee is to license people to make sure they are competent. When they put that certificate on the wall, the state is vouching that they're competent.

--official Minutes

"Boards typically open cases on the basis of complaints or referrals made to them. If they are to become major players in the quality assurance field, this reactive mode is insufficient. They must find ways of preventing or minimizing harm, not just responding once harm is done."

--Mark R. Yessian, PhD, "State Medical Boards and Quality Assurance," *Federation Bulletin*, September 1992, Federation of State Medical Boards

Table 8. Examination Data				
California Examination (include multiple language) if any: NONE				
License Type		N/A	N/A	N/A
Exam Title				
FY 2007/08	# of 1 st Time Candidates			
	Pass %			
FY 2008/09	# of 1 st Time Candidates			
	Pass %			
FY 2009/10	# of 1 st Time Candidates			
	Pass %			
FY 2010/11	# of 1 st time Candidates			
	Pass %			
Date of Last OA				
Name of OA Developer				
Target OA Date				
National Examination (include multiple language) if any: American Podiatric Medical Licensing Exam				
License Type		DPM		
Exam Title		Part III		
FY 2007/08	# of 1 st Time Candidates	43		
	Pass %	96%		
FY 2008/09	# of 1 st Time Candidates	52		
	Pass %	93%		
FY 2009/10	# of 1 st Time Candidates	45		
	Pass %	96%		
FY 2010/11	# of 1 st time Candidates	49		
	Pass %	94%		
Date of Last OA		2008		
Name of OA Developer		NBPME		
Target OA Date		2013		

1

2

3 Examinations

4 21. Describe the examinations required for licensure. Is a national exam used? Is there a California
5 specific exam required?

6 The examinations required for licensure, pursuant to B&P Section 2486, are Parts I, II and III of the American
7 Podiatric Medical Licensing Examination (APMLE) of the National Board of Podiatric Medical Examiners
8 (NBPME). This is a national exam. As recommended by the Department and the Joint Committee during
9 BPM's last sunset review, the Board sunsetted its state oral clinical exam and began requiring Part III in
10 addition to the first two parts of APMLE. This was codified by SB 1955 of 2002. APMLE Parts I and II are
11 taken during podiatric medical school, and must be passed prior to BPM's issuance of a Resident's License for
12 postgraduate training [B&P Code §2475.1]. Part III is the clinical competence portion, i.e., the national

1 licensure exam, taken during postgraduate training, and must be passed prior to BPM's issuance of the DPM
2 license.

3
4 22. What are pass rates for first time vs. retakes in the past 4 fiscal years? (*Refer to Table 8: Exam*
5 *Data*)

6 Pass rates for first time examinees range from 93-96 percent, as indicated in Table 8. There were two
7 candidates retaking the Part III exam in FY 2007/08 and four in FY 2008/09. All six of these candidates passed.
8 There were no retakes in FYs 2009/10 or 2010/11.

9
10 23. Is the board using computer based testing? If so, for which tests? Describe how it works. Where
11 is it available? How often are tests administered?

12 APMLE Parts I, II and III are all computer based. Testing for Parts I and II are given three times a year while
13 Part III is offered twice a year.

14
15 Part I is taken upon completion of the second year of podiatric medical school. It focuses on basic sciences.

16 Part II is taken near the completion of the candidate's final, fourth year of study. This portion of the testing
17 covers General Medicine.

18
19 Part III is a licensing exam that is designed to determine whether a candidate's knowledge and clinical skills are
20 adequate for safe practice. NBPME has updated Part III as of the June 2011 exam, as discussed in the next
21 question.

22
23 NBPME selects computerized testing centers for each exam based on the number and location of candidates
24 who register.

25
26 24. Are there existing statutes that hinder the efficient and effective processing of applications and/or
27 examinations? If so, please describe.

28 Yes. B&P Section 2493(b).

29
30 AB 932 [Koretz, Statutes of 2004, Chapter 88], sponsored by the California Podiatric Medical Association,
31 amended B&P Code §2493 to reflect the change it made in §2484 upping the graduate medical education
32 requirement for DPMs from one to two years.

33
34 Section 2493 (see full text appended to this report) was amended to require "a passing score one standard error
35 of measurement higher than the national passing scale score" on APMLE Part III.

36
37 This technical language was added by AB 932 pursuant to association negotiations with input from the Board,
38 the National Board of Podiatric Medical Examiners, and the Department's Office of Examination Resources
39 (OER), which raised concern about such technical language being included in the statute.

40
41 NBPME utilizes a national passing scale score of 75, after converting actual raw scores on individual exams to
42 scaled scores allowing comparison with the scores of applicants taking previous administrations of the exam.
43 The scale passing score corresponds to a level of achievement judged by NBPME to represent entry-level
44 competence.

45
46 Nationally, passing rates on Part III have ranged between 80-90 percent. During its history from November
47 1984 to May 2002, BPM's oral clinical licensing exam had a 76 percent pass rate (1,269 of 1,667).

1 In BPM's experience, the California score, one standard error of measurement higher than the national scale
2 passing score, raises the passing score from 75 one or two points, e.g., to 77, and lowers the overall pass rate
3 percentage from the high 80s to the low 80s. Numerically, this means that for each biannual Part III exam, one
4 or two California candidates might achieve the national scale passing score of 75 but fall just below California's
5 one standard error of measurement higher, and must retake the examination.

6
7 BPM's requirement by law for a higher score than the national passing score confuses and disappoints
8 applicants, and delays or blocks their entering practice, sometimes losing job offers in the process. In the
9 judgment of BPM's professional staff it has a marginal if any effect on the quality of licensees and patient care.

10

11 In June 2011, the Executive Director of the NBPME informed BPM that it was revising the Part III exam to
12 reflect the level of competence expected following one year of graduate medical education (residency training),
13 an upgrade from the previous competency level reflecting graduation from podiatric medical school.

14

15 In August 2011 he reported: "The June 2011 examination and all subsequent forms will include a board-adopted
16 passing score that reflects entry-level competence by a podiatric physician with one year of post-graduate
17 training."

18

19 With this step, BPM recommends deleting B&P Section 2493(b) as indicated in the appendix.

20

21 Section 2493(b) requires a passing score consistent with Section 2484. Section 2484 requires two-years of
22 postgraduate training for California licensure. However, California is the only one of the 50 States to require
23 more than one year, and the Medical Board of California requires only one year for MDs. For licensure, the
24 one-year NBPME standard is a satisfactory advance and reasonably consistent with Section 2484.

25

26 Part III already examines for the full scope of podiatric medical practice in California established in Section
27 2472 and referenced in Section 2493(b). BPM's concern has always been that it does so at a competency level
28 expected following postgraduate training.

29

30 While some negotiating AB 932 wanted a more rigorous exam, comparable to BPM's sunsetted oral clinical
31 exam or the American Board of Podiatric Surgery's specialty certification exam, B&P Code Sections 2492 and
32 2493, and the Department of Consumer Affairs' *Examination Validation Policy* developed under B&P §139,
33 require a *licensing* exam testing for "entry-level competence." Part III is equivalent to the USMLE Step 3
34 licensing exam taken by first-year MD residents, which is itself distinct from medical specialty exams
35 administered by boards recognized by the American Board of Medical Specialties (ABMS).

36

37 BPM recommends sunseting Section 2493(b).

38

39 **School approvals**

40 25. Describe legal requirements regarding school approval. Who approves your schools? What role
41 does BPPE have in approving schools? How does the board work with BPPE in the school
42 approval process?

43 BPM has authority to approve schools of podiatric medicine pursuant to B&P Code Sections 2475, 2476, 2483,
44 2486, and 2488. BPM's regulations (1399.662 -- Approved Schools) require that schools be accredited by the
45 national Council on Podiatric Medical Education (CPME), which is designated for this purpose by the U.S.
46 Department of Education. BPPE does not approve medical and podiatric medical schools.

47

48

1 26. How many schools are approved by the board? How often are schools reviewed?

2 CPME has accredited eight schools and in addition has granted candidate status to the College of Podiatric
3 Medicine at Western University of Health Sciences in Pomona, CA. An institution that has achieved candidate
4 status is viewed by the Council to have satisfied the eligibility requirements and to have the potential for
5 meeting CPME accreditation standards and requirements once the DPM program is fully activated with students
6 enrolled in all four years.

7
8 CPME re-evaluates accredited podiatric medical schools on a regular basis. According to its publication *CPME*
9 *130*: "In order for accreditation to be reaffirmed, the Council conducts re-evaluation of the institution on a
10 periodic basis." This involves a comprehensive on-site evaluation.

11

12 27. What are the board's legal requirements regarding approval of international schools?

13 BPM's regulations require that schools be accredited by the CPME, which to date has only approved schools
14 within the U.S. To date, there are no comparable four-year podiatric medical schools in other countries offering
15 the DPM degree.

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Section 5 – Enforcement Program

28. What are the board's performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

In January 1990, BPM staff instituted new complaint tracking goals. The new staff goals were 24-hours for Executive Officer review, 30 days for DPM medical consultant review, and six months for MBC investigators.

SB 2375 of 1990, which BPM was the first State agency to support, enacted Business & Professions Code Section 2319, which mandated that the Medical Board "set as a goal ... so that an average of no more than six months will elapse from the receipt of complaint to the completion of an investigation.... The goal...for cases which ... involve complex ... issues ... should be no more than one year to investigate."

The BPM Board Members at that time requested initiation of a Medical Board Enforcement Matrix Report that would show, for MBC, BPM, and all other health boards affiliated at that time with MBC, the number of cases in the system at each step and how long they had been there. This proved controversial. While other affiliated health boards dropped out, the report was continued for MDs and DPMs despite ongoing resistance for several years and has been a valuable management tool. MBC managers used it to clean up the data base, so that MBC would have reliable data. BPM exhibits it in each quarterly Board Member meeting agenda book.

BPM's timelines are reasonably within B&P Code Section 2319's statutory goals for Medical Board investigations (180 days on average, 360 for complex cases). BPM is also reasonably close to the new Department of Consumer Affairs target cycle time. DCA's goal is 12-18 months from receipt of complaint to completion of investigation and final decision.

BPM will continue improvements. Twenty years ago, BPM became the first of the health boards affiliated with the Medical Board to hire a full-time Enforcement Coordinator.

As noted above, BPM is part of the Medical Board and it is in fact the MBC that issues DPM licenses. The Medical Board also handles BPM complaint and enforcement cases under an annual Shared Services agreement, funded by BPM's budget, which is efficient given BPM's less than 2,000 licensees and five (5) staff.

Under Shared Services, MBC:

- Receives, processes, coordinates and tracks DPM complaints in its Central Complaint Unit
- Sends cases to DPM consultants, in coordination with BPM's Enforcement Coordinator, in quality/standard of care cases
- Sends cases to Medical Board investigators, as appropriate
- Sends cases to BPM's DPM expert reviewers/witnesses when DPM consultants determine indepth review indicated
- Refers cases to the Attorney General, as appropriate
- Processes and manages proposed decisions, stipulated agreements, mail ballots to BPM Board Members, and final decisions, and coordinates petitions and court appeal documents

- Reports data to BPM in the Enforcement Matrix Report referenced above
- Reports BPM Accusations, Statements of Issue, and final decisions in its MBC Action Report

BPM's Enforcement Coordinator assists, facilitates and expedites this entire process. Central to BPM's mission is an emphasis on the quality and appropriateness of case handling, in addition to moving cases expeditiously. Justice delayed is justice denied, but inadequate plea bargaining could negate justice altogether and undermine BPM's consumer protection law enforcement.

The Enforcement Coordinator monitors each case to ensure adherence to at least the minimum disciplinary standards in the Board's adopted Regulations (*Manual of Disciplinary Guidelines*).

Strong enforcement and weak enforcement each send a message. Strong enforcement (and high licensing standards) reinforce high professional standards, which lead to higher-quality care, less patient harm, fewer complaints, and fewer costly enforcement cases (after the patient harm has already been suffered).

With the Governor's Consumer Protection Enforcement Initiative (CPEI), the Medical Board will receive authority to hire non-sworn investigators to help expedite investigations. One-half of one of these positions will be dedicated to DPM cases and funded by BPM's budget. This .5 non-sworn addition to the boots on the ground beginning after July 1, 2010, will assist the Medical Board's ability to move BPM cases. The BPM Enforcement Coordinator will monitor this and add assistance to the non-sworn investigators to her daily program.

29. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

The most significant trend in BPM data is the nationally-unique decline in complaints, more than a 50-percent steady longitudinal decline over the last decade.

What is BPM doing different? It is part of the Medical Board, its enforcement is handled by the same Medical Board and Attorney General staff. It utilizes the same enforcement laws.

BPM continues to prosecute a vigorous enforcement program. In part because it has fewer cases and has a full-time enforcement coordinator dedicated to expediting and overseeing the system, BPM is able to micromanage cases and has not infrequently been told for years that it tends to seek and obtain stronger results in final orders.

This sent a message decades ago and no doubt has an effect. The Board is viewed as strong, tough, and public-minded. However, good results for licensing boards depend as much--or more--on licensing. Licensing must not be shortchanged. It may not be wise to rationalize that boards can catch up to questionable providers in their enforcement programs (at great expense, and after much harm to Californians has been done--irreparably, to people).

BPM remains the only health licensing board in the country to have implemented a Continuing Competence program.

BPM may be the only health licensing board in California to have sponsored legislation writing Primary Source Verification (PSV) of licensing standards written into its law.

1 BPM is the only doctor-licensing board in the State to require two-years of postgraduate training, long
2 recognized as a minimum standard for licensing.

3
4 BPM devised the MBC Enforcement Matrix Report in the early 1990s, which was bitterly opposed over several
5 years but helped bring accountability to this area of State government. Career MBC staff used it to clean up the
6 data base so that MBC and BPM had reasonably accurate management and public reporting data. BPM has
7 monitored this data in part to evaluate whether MBC and the AG service DPM cases equally to MD cases.
8 They consistently have. The Matrix Report is designed to show timelines, i.e., where cases are in the system
9 and how long they have been there.

10
11 The strength of DCA is the career civil-service. BPM supports strong good-government stewardship to aid
12 board and bureau consumer protection law enforcement. Strengthening the Department could be much to the
13 purpose of associations and the State economy as well as to our citizens as individual consumers.

14
15 Increased special fund assessments could support:

- 16
17 • Establishing a Policy Analysis unit arming the DCA Director with rigorously developed options, pros and
18 cons. With inter-disciplinary career staff (MPA, MBA, economists *et cet*), it could vet public policy issues
19 professionally with input from constituents and stakeholders, clarifying issues in the face of conflicting
20 claims.
21 .
22 • Public-service advertizing of a single DCA toll-free help & complaint line with multi-lingual staff
23 connecting callers with appropriate board and bureau personnel. Given the numbers of boards for
24 Californians to keep track of, Departmental coordination seems preferable to Balkanization of effort.
25
26 • Upgrading the internal audit unit into a semi-independent Inspector General with multi-disciplinary
27 professional staffing.
28
29 • Upgrading office of exam resources with professionally-credentialed staff and management.
30
31 • Reduction of paper work, bureaucratic meetings, red tape, duplicative reporting, and unnecessary
32 rulemaking to free staff for customer service and consumer protection.
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Table 9a. Enforcement Statistics			
	FY 2008-09	FY 2009-10	FY 2010-11
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	107	116	90
Closed	0	0	0
Referred to INV	108	115	86
Average Time to Close	10	20	10
Pending (close of FY)	3	4	0
Source of Complaint (Use CAS Report 091)			
Public	69	87	26
Licensee/Professional Groups	2	10	4
Governmental Agencies	1	2	0
Other	36	27	60
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	1	12	5
CONV Closed	1	12	5
Average Time to Close	15	9	22
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied	0	0	1
SOIs Filed	0	2	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0	0	555
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	4	6	8
Accusations Withdrawn	0	0	2
Accusations Dismissed	0	0	0
Accusations Declined	0	1	0
Average Days Accusations	1060	808	660
Pending (close of FY)	10	9	13

Table 9b. Enforcement Statistics (continued)			
	FY 2008-09	FY 2009-10	FY 2010-11
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	2	2	1
Stipulations	8	5	2
Average Days to Complete	1060	808	660
AG Cases Initiated	6	9	11
AG Cases Pending (close of FY)	10	9	13
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	2	1	0
Voluntary Surrender	0	1	1
Suspension	0	0	0
Probation with Suspension	1	1	0
Probation	5	4	2
Probationary License Issued	0	0	0
Other	1	0	0
PROBATION			
New Probationers	7	5	1
Probations Successfully Completed	4	5	9
Probationers (close of FY)	19	19	15
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	1	1	1
Probations Extended	0	0	1
Probationers Subject to Drug Testing	0	0	4
Drug Tests Ordered	0	0	86
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	1	1
DIVERSION			
New Participants	0	0	0
Successful Completions	0	0	0
Participants (close of FY)	0	0	0
Terminations	0	0	0
Terminations for Public Threat	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0

Table 9c. Enforcement Statistics (continued)				
		FY 2008-09	FY 2009-10	FY 2010-11
INVESTIGATION				
All Investigations	(Use CAS Report EM 10)			
First Assigned		109	127	91
Closed		112	115	111
Average days to close		207	168	191
Pending (close of FY)		53	65	45
Desk Investigations	(Use CAS Report EM 10)			
Closed		109	96	77
Average days to close		135	116	103
Pending (close of FY)		36	31	23
Non-Sworn Investigation	(Use CAS Report EM 10)			
Closed		0	0	0
Average days to close		0	0	0
Pending (close of FY)		0	0	0
Sworn Investigation				
Closed	(Use CAS Report EM 10)	22	19	34
Average days to close		502	431	393
Pending (close of FY)		17	34	22
COMPLIANCE ACTION (Use CAS Report 096)				
ISO & TRO Issued		0	1	0
PC 23 Orders Requested		1	0	0
Other Suspension Orders		1	0	0
Public Letter of Reprimand		0	0	0
Cease & Desist/Warning		5	2	0
Referred for Diversion		n/a	n/a	n/a
Compel Examination		0	0	0
CITATION AND FINE* (Use CAS Report EM 10 and 095)				
Citations Issued		4	4	0
Average Days to Complete		485	586	0
Amount of Fines Assessed		1,000	2,500	0
Reduced, Withdrawn, Dismissed		2	3	0
Amount Collected		500	900	1,600
CRIMINAL ACTION				
Referred for Criminal Prosecution		0	0	0

*Citation and Fine reporting definitions:

- Citations Issued – All issued including those reduced, withdrawn or dismissed.
- Amount of Fines Assessed – Executive Officer's final assessment (after any informal conference).
- Reduced, Withdrawn, Dismissed – Withdrawn is by Executive Officer following informal conference and compliance obtained. Reduced or Dismissed would be by the Board's adoption of an Administrative Law Judge's Proposed Decision dismissing the citation or reducing the fine, following an Administrative Procedure Act appeal. There were no such appeals in these three FYs.
- Amount Collected – Fine amounts collected in this FY on all fines past and present.

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Table 10. Enforcement Aging						
	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11	Cases Closed	Average* %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	7	3	2	0	12	38.5
2 Years	2	7	1	2	12	38.5
3 Years	1	1	3	1	6	19.5
4 Years	0	0	1	0	1	3.5
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	10	11	7	3	31	
Investigations (Average %)**						
Closed Within:						
90 Days	2	0	2	3	7	7.5
180 Days	0	3	4	4	11	11.5
1 Year	9	6	5	8	28	29.5
2 Years	6	9	3	17	35	37
3 Years	2	5	5	2	14	14.5
Over 3 Years	0	0	0	0	0	0
Total Cases Closed	19	23	19	34	95	

2 *Percentages have been rounded up or down.

3 **These numbers only represent the investigations that were sent to the field, not complaints classified as desk investigations in the
4 Consumer Affairs System (CAS) prior to being closed.

5

6 30. What do overall statistics show as to increases or decreases in disciplinary action since last
7 review.

8 Overall, statistics indicate that BPM has stayed the course in maintaining a strong, meaningful enforcement
9 program since 2001.

10

11 31. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from
12 DCA's model? If so, explain why.

13 BPM complaints are managed by the Medical Board Central Complaints Unit identically to MD cases,
14 following the same MBC and DCA prioritization policies. BPM's Enforcement Coordinator works to expedite
15 appropriate handling of each and every complaint. To BPM, there is no low priority complaint.

16

17 32. Are there mandatory reporting requirements? For example, requiring local officials or
18 organizations, or other professionals to report violations, or for civil courts to report any actions
19 taken against the licensee. Are there problems with receiving the required reports? If so, what
20 could be done to correct the problems?

21 SB 1438 [Figueroa, Statutes of 2006, Chapter 223] updated and clarified language in Article 11 (Professional
22 Reporting) of the B&P Code, beginning with Section 800. This included BPM recommendations to ensure
23 coverage of DPMs. These sections of Article 11 require insurers, doctors, prosecuting attorneys, courts,
24 coroners, peer review bodies and health facilities to report to the Medical Board on MDs or DPMs in regard to

1 malpractice (settlements, arbitrations and judgments), felony charges, criminal convictions, patient deaths
2 resulting from gross negligence or incompetence, and negative staff-privileging actions.

3

4 The MBC Central Complaint Unit receives these reports. BPM will defer to the Medical Board regarding
5 compliance.

6

7 33. Does the board operate with a statute of limitations? If so, please describe and provide citation. If
8 so, how many cases were lost due to statute of limitations? If not, what is the board's policy on
9 statute of limitations?

10 No cases were lost due to the applicable statute of limitations found in B&P Code:

11

12 2230.5. (a) Except as provided in subdivisions (b), (c), and (e),
13 any accusation filed against a licensee pursuant to Section 11503 of
14 the Government Code shall be filed within three years after the
15 board, or a division thereof, discovers the act or omission alleged
16 as the ground for disciplinary action, or within seven years after
17 the act or omission alleged as the ground for disciplinary action
18 occurs, whichever occurs first.

19 (b) An accusation filed against a licensee pursuant to Section
20 11503 of the Government Code alleging the procurement of a license by
21 fraud or misrepresentation is not subject to the limitation provided
22 for by subdivision (a).

23 (c) An accusation filed against a licensee pursuant to Section
24 11503 of the Government Code alleging unprofessional conduct based on
25 incompetence, gross negligence, or repeated negligent acts of the
26 licensee is not subject to the limitation provided for by subdivision
27 (a) upon proof that the licensee intentionally concealed from
28 discovery his or her incompetence, gross negligence, or repeated
29 negligent acts.

30 (d) If an alleged act or omission involves a minor, the seven-year
31 limitations period provided for by subdivision (a) and the 10-year
32 limitations period provided for by subdivision (e) shall be tolled
33 until the minor reaches the age of majority.

34 (e) An accusation filed against a licensee pursuant to Section
35 11503 of the Government Code alleging sexual misconduct shall be
36 filed within three years after the board, or a division thereof,
37 discovers the act or omission alleged as the ground for disciplinary
38 action, or within 10 years after the act or omission alleged as the
39 ground for disciplinary action occurs, whichever occurs first. This
40 subdivision shall apply to a complaint alleging sexual misconduct
41 received by the board on and after January 1, 2002.

42 (f) The limitations period provided by subdivision (a) shall be
43 tolled during any period if material evidence necessary for
44 prosecuting or determining whether a disciplinary action would be
45 appropriate is unavailable to the board due to an ongoing criminal
46 investigation.

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1 **Cite and Fine**

2
3 34. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes
4 from last review and last time regulations were updated. Has the board increased its maximum
5 fines to the \$5,000 statutory limit? **and**

6 35. How is cite and fine used? What types of violations are the basis for citation and fine?
7

8 BPM's cite and fine regulations are in California Code of Regulations, Title 16, Division 13.9, Article 8,
9 §1399.696.

10
11 Citation and fine remains an effective tool for BPM to obtain compliance in advertizing, record keeping and
12 other such cases when they do not seem to rise to the level of an Accusation. There is no significant change
13 from the last review.

14
15 BPM was among the first to implement non-disciplinary citation and fine authority, filing regulations in 1988
16 that became operative that same year [Register 88, No. 37]. Beginning in the early 1990s, BPM used this
17 authority to respond, some felt zealously, to advertising violations and lax compliance with certain licensing
18 requirements, such as timely renewal and the license requirement for postgraduate training.

19
20 With greater awareness and compliance, there are now fewer violations at the cite and fine level. In the last
21 review, the Joint Committee raised concerns about BPM's intention to use citations in lower-priority quality of
22 care cases, which in fact has not proved a useful or significant element of the enforcement program.

23
24 BPM last updated its cite and fine regulations in 2008 (Register 2008, No. 20) to add new Division 13.9,
25 Section 1399.696 subsections (c)(61), (d) and (e). These added authority to cite for failure to produce medical
26 records, increased the maximum fine to \$5,000 with qualifying language mandated to all boards at the time by
27 the Schwarzenegger Administration (which in BPM's practice would tend to elevate cases above the citation
28 level, i.e., to the filing of an Accusation), and authority to cite for a failure to comply with a term and condition
29 of probation.

30
31 BPM does not utilize citation and fine against technical violations such as forgetting to notify the Board
32 promptly of address changes. The executive officer routinely issues the preliminary citation at the \$2,500
33 amount, which typically obtains the licensee's attention. All eight of the citations issued in the three FYs
34 covered in Table 9c were initially \$2,500 prior to the informal conference, which provides the licensee an
35 opportunity to tell their side of the story and agree to any compliance indicated.

36
37 BPM will withdraw the citation or significantly reduce the fine following the informal conference based on
38 compliance obtained, if the doctor evidences good faith as is often the case. Thus it becomes an educational
39 process winning the licensee's understanding and higher standard in the future. Of the eight citations in Table
40 9c, five were withdrawn based on compliance and evidence obtained at the informal conference. Of the three
41 not withdrawn, two of the fines were reduced to \$500. In the third, the licensee paid the \$2,500 without
42 requesting an informal conference.

43
44 36. How many informal office conferences, Disciplinary Review Committees reviews and/or
45 Administrative Procedure Act appeals in the last 4 fiscal years?

46 In the past four fiscal years there were seven (7) informal office conferences and no Administrative Procedure
47 Act appeals. The Board does not utilize Disciplinary Review Committees.

1 37. What are the 5 most common violations for which citations are issued?

2 In the past four fiscal years, the most frequently cited violation in BPM's citations (four issued in the past four
3 fiscal years) has been B&P Code Section 2266 (Failure to Maintain Adequate Records). The only other three
4 violations that have been cited are one citation issued for §2225.5 (Failure to Release Patient Records), two
5 citations issued for §2234 (Unprofessional Conduct), and two citations issued for §2264 (Aiding Unlicensed
6 Practice of Medicine).

7
8 38. What is average fine pre and post appeal?

9 The average fine was \$1,167 (one at \$2,500 and two at \$500). There were no appeals to an Administrative
10 Procedure Act hearing before an Administrative Law Judge, so the post appeal amount remained the same.

11
12 39. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

13 None to date. As part of the Medical Board, BPM utilizes MBC discipline coordination and enforcement staff
14 offices, and the Attorney General's Health Quality Enforcement Unit, as necessary.

15 16 17 **Cost Recovery and Restitution**

18
19 40. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

20 While part of the Medical Board, and though utilizing MBC staff for enforcement, BPM has cost recovery
21 authority (B&P §2497.5) while MBC does not (B&P §125.3(k)).

22
23 BPM's precedent-setting cost recovery program was established by SB 1503 [Statutes of 1984, Chapter 695]
24 and amended by SB 1879 [Statutes of 1986, Chapter 655].

25
26 BPM's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* provides that cost recovery is a
27 standard condition for all cases:

28
29 <http://bpm.ca.gov/lawsregs/dgl.pdf>

30 Administrative Law Judges (ALJs) are uneven in the amount of cost recovery they propose from one case to
31 another. In stipulated agreements, the Board's staff and Attorney General always seek cost recovery as part of
32 the negotiation, second only to negotiating provisions aimed at enhancing public protection, which is the
33 Board's mission, and without which the Board will go to hearing rather stipulating to a settlement. The Board
34 has also made payment of probation monitoring costs a standard condition in the *Manual* pursuant to B&P
35 §2222 and §2227(a)(3) of Article 12 (Enforcement) of the Medical Practice Act.

36
37 BPM recommends amending B&P §2497.5(b):

38 2497.5. (a) The board may request the administrative law judge, under his or her proposed
39 decision in resolution of a disciplinary proceeding before the board, to direct any licensee found
40 guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable
41 costs of the investigation and prosecution of the case.

42 (b) The costs to be assessed shall be fixed by the administrative law judge and shall not ~~in any~~
43 ~~event be increased by the board unless the board does not adopt a proposed decision and in~~
44 ~~making its own decision finds grounds for increasing the costs to be assessed. When the~~
45 ~~board does not adopt a proposed decision and remands the case to an administrative law~~

~~judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.~~

41. How many and how much is ordered for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

In the past four fiscal years, the Board has ordered \$112,806 in cost recovery for a total of 15 disciplinary cases it adopted from Proposed Decisions or Stipulated Agreements. It has collected \$110,560 over the same period of time. While the amount collected in a given fiscal year is not directly related to the cases for which cost recovery was ordered during the same year, this remains indicative of BPM's effort to ensure full compliance with the terms and conditions of each disciplinary order.

BPM believes all current outstanding costs are collectable. All cases in which there is an outstanding cost recovery balance pertain to active licensees.

42. Are there cases for which the board does not seek cost recovery? No. Why? N.A.

43. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

None to date. As part of the Medical Board, BPM utilizes MBC discipline coordination and enforcement staff offices, and the Attorney General's Health Quality Enforcement Unit, of which the MBC is the chief client. Under Section 125.3 (k) the MBC "shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licentiate."

44. Does the board have legal authority to order restitution? If so, describe the board's efforts to obtain restitution for individual complainants, the board's formal restitution program, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Discuss any changes since last review.

Outside of insurance fraud (B&P Code §810), licensing boards have limited authority for seeking restitution (see B&P §125.5). Many physician complaints do come to MBC Central Complaints as a result of malpractice filings, and it is the civil malpractice system in which restitution is generally addressed (even before the case comes before MBC). Administrative discipline under the Medical Practice Act is oriented principally toward protection of future patients through licensee discipline, while the civil malpractice system is extensively used for restitution to former patients. MBC and BPM have no jurisdiction over billing issues outside of insurance fraud.

	MALPRACTICE	DISCIPLINE
Venue	Civil court	Administrative law
Trier	Judge	Administrative Law Judge
Jury	Lay	Licensee majority
Required evidence	Preponderance	Clear and convincing
Primary purpose	Compensate former patient	Protect future patients
Primary result	Monetary award or settlement	Revocation, suspension, probation of license

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Malpractice attorneys may advise clients to accept monetary settlement in lieu of going to civil trial given a case's strength relative to the *preponderance of the evidence* test. With the even higher standard in administrative law, some patients may consider monetary settlement in the civil arena a good result. A monetary settlement may bring better closure to some patients than would a closure letter from the Medical Board in cases where the Attorney General is unlikely to see *clear and convincing* arguments that the doctor acted below the range of the community standard of care.

While restitution is usually addressed prior to the administrative hearing before an ALJ, BPM's *Manual of Disciplinary Guidelines*, promulgated as guidance to the Attorney General and Administrative Law Judges (ALJs), provides the following language for "restitution to consumers or other injured partners":

Within 90 days of the effective date of this Decision, respondent shall provide proof to the BPM or its designee of restitution in the amount \$_____ paid to _____. Failure to pay restitution shall be considered a violation of probation.

NOTE: In offenses involving economic exploitation, restitution is a necessary term of probation. For example, restitution would be a standard term in any case involving Medi-Cal or other insurance fraud. The amount of restitution shall be no less than the amount of money that was fraudulently obtained by the licensee. Evidence relating to the amount of restitution would have to be introduced at the administrative hearing.

- 1 With regard to this issue, the MBC and Joint Legislative Sunset Review Committee have previously reported:
 2 [http://www.senate.ca.gov/ftp/SEN/COMMITTEE/JOINT/SUNSET_REVIEW/ home/MED BOARD](http://www.senate.ca.gov/ftp/SEN/COMMITTEE/JOINT/SUNSET_REVIEW/home/MED_BOARD_2002_SUNSET_REVIEW_REPORT.DOC)
 3 [2002 SUNSET REVIEW REPORT.DOC](http://www.senate.ca.gov/ftp/SEN/COMMITTEE/JOINT/SUNSET_REVIEW/home/MED_BOARD_2002_SUNSET_REVIEW_REPORT.DOC)

4 RESTITUTION PROVIDED TO CONSUMERS

5 Public Protection Versus Damages

6 Only rarely does the Board seek restitution for damages done to individual consumers.
 7 Historically, restitution for damages caused by substandard or reckless medical practice is handled
 8 in superior court, through civil malpractice cases.

9
 10 The primary responsibility of the Board is to protect consumers from substandard or dishonest
 11 practitioners, whether or not damage has occurred. Civil malpractice cases are for the purpose of
 12 seeking recompense for damages to an individual, whether or not the conduct poses a danger to the
 13 public. Conversely, while substandard care may cause no damage to an individual patient, the
 14 conduct may be potentially dangerous and pose a threat to future patients. (As an example, a
 15 simple error or act that is neither legally negligent or incompetent may cause great damage and
 16 therefore is legal cause for a large malpractice award or settlement. Conversely, a terribly
 17 negligent or incompetent act may not cause any harm in a single instance, and therefore may be
 18 subject for discipline, but will not yield any civil award or settlement as no damage was done.)

19
 20 While the Medical Boards complaint staff often mediates between patients and their physicians on
 21 minor, technical issues such as obtaining medical records, they cannot act as mediators to obtain
 22 sufficient financial redress for serious damages caused by medical malpractice, such as wrongful
 23 death or loss of bodily function.
 24

Table 11. Cost Recovery

	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
Total Enforcement Expenditures	299,750	276,418	311,345	377,876
Potential Cases for Recovery *	5	8	6	3
Cases Recovery Ordered	4	6	3	2
Amount of Cost Recovery Ordered	27,050	32,084	34,872	18,800
Amount Collected**	36,937	11,867	32,966	28,790

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation(s) of the license practice act. B&P Code §2497.5 (a) states "The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case."

**Amount collected in a given fiscal year is not directly related to the cases for which cost recovery was ordered during that same year. Amounts ordered are not necessarily due within the same fiscal year, and are often paid over a number of years (e.g. 3 year payment plan).

Table 12. Restitution

	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
Amount Ordered	0	0	0	0
Amount Collected	0	0	0	0

Section 6 – Public Information Policies

45. How does the board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The Board posts agenda and meeting materials online at least 10 days prior to public meetings. They remain on the website continuously. Draft meeting minutes are posted as soon as drafted. Final minutes are posted immediately following their approval by the Board at a public meeting. They remain on the website continuously.

46. Does the board webcast its meetings? How far in advance does the board post future meeting dates?

BPM initiated webcasting in 2010 with the February 18 meeting in Los Angeles. Meeting dates for each year are established by the Board at the last meeting of the previous year, and those dates are immediately posted online.

47. Are the board's complaint disclosure policies consistent with DCA's complaint disclosure and public disclosure policies?

BPM was the first board to implement the Department's *Recommended Minimum Standards for Consumer Complaint Disclosure*, which "were adopted following a series of public hearings throughout the state. Those hearings drew extensive interest from consumer groups, professional associations, the press, law enforcement and regulatory agencies. The input received was enormously insightful and helped shape the final standards. The Department's regulatory Bureaus have been directed to implement these procedures and the Department's regulatory Boards have been asked to consider adopting policies consistent with that of the Department."

http://www.dca.ca.gov/about_dca/disclosure.shtml

http://www.dca.ca.gov/about_dca/disclosure_standards.shtml

BPM's regulations were drafted by the DCA Legal Office to implement this and are contained in Article 9 of its regulations. Disclosure of complaints pursuant to the Minimum Standards ("the complaint will be referred for legal action") is specifically addressed in Section 1399.704.

Under these BPM regulations approved by the Office of Administrative Law (OAL) in 2004, BPM discloses referrals to the Attorney General without waiting for preparation of a formal Accusation. BPM believes this information should be disclosed to prospective, inquiring patients.

BPM's regulations in effect disclose complaints when they are referred to the Attorney General, which the former Director had made the departmental standard, at the recommendation of BPM and others. In the event, BPM's Board had to vote unanimously to override her veto of the proposed regulations. The Office of Administrative Law (OAL) examined the legality of disclosing referrals to the AG and upheld BPM's position, which has been adopted by at least one other health board. In approving BPM's regulations, OAL considered the contention that disclosure of AG referrals is prohibited and rejected it.

1 The BPM Board Members decided they could not justify telling trusting Californians scheduled for surgery, and
 2 calling BPM for information, that there is no adverse public information to disclose if the Board has already
 3 fully investigated complaints and referred their surgeon to the Attorney General for prosecution due to
 4 incompetence, gross negligence or other unprofessional conduct.

5
 6 The Medical Board handles DPM verifications through budgeted Shared Services, but does not include AG
 7 Referrals information. Nor is such information included in official online verifications. Referrals are only
 8 disclosed on BPM's web site or by BPM staff over the telephone, and only for DPMs.

9
 10 BPM does not concur in statements made at DCA Board Member Orientation and Training sessions that there
 11 are "a lot of problems" with disclosing referrals to the AG and that boards should not consider it. BPM has not
 12 experienced any problems.

TYPE OF INFORMATION PROVIDED	YES	NO
Complaint Filed		X
Citation	X	
Fine	X	
Letter of Reprimand	X	
Pending Investigation		X
Investigation Completed		X
Arbitration Decision	X	
Referred to AG: Pre-Accusation	X	
Referred to AG: Post-Accusation	X	
Settlement Decision	X	
Disciplinary Action Taken	X	
Civil Judgment	X	
Malpractice Decision	X	
Criminal Violation: Felony Misdemeanor	X	X

16
 17

18 48. What information does the board provide to the public regarding its licensees (i.e., education
 19 completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

20 BPM provides the license type and number, address of record, podiatric medical school attended with
 21 graduation date, license status, original issue date and expiration date, and any public record or disciplinary
 22 information.

23
 24 49. What methods are used by the board to provide consumer outreach and education?

25 BPM's website is rich with consumer information at the Consumer tab and other locations. This includes
 26 BPM's own DCA-published brochures in English and Spanish such as *You and Your DPM*, *Orthotics Can Help*,

1 and *Diabetics--Keep an Eye on Your Feet*. With travel restricted, BPM works closely with DCA's publications
2 and outreach offices to have its brochures widely distributed through the Department's coordinating efforts.

3
4 Given the alphabet soup of boards and bureaus, it might be practicable for the Department of Consumer Affairs
5 to coordinate more outreach with a single toll-free number staffed with multi-lingual referral personnel on
6 behalf of all DCA special-funded programs. Costs, including public service advertising, could be reimbursed
7 through assessments of special funds.

8
9 BPM's website also provides links to many consumer advocacy and advice organizations.

Section 7 – Online Practice Issues

50. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate Internet business practices or believe there is a need to do so?

There are no plans at this time for new, additional regulatory approaches designed especially to target Internet business. With few exceptions, e.g., one case involving a Texas licensee, now revoked by the Texas State Board of Podiatric Medical Examiners and the U.S. Drug Enforcement Administration, there has not been marked evidence of DPM-related Internet business activity. DEA reports regarding this doctor, Salvatore DeFrank (who once held a California license that expired in 1990):

http://www.deadiversion.usdoj.gov/fed_regs/actions/2005/fr05183.htm

On September 15, 2004, Dr. DeFrank was interviewed by two detectives from the Sheriff's Department of Ventura County, California. Dr. DeFrank admitted he was then-currently managing a web site call center which employed one physician and a physician's assistant to issue controlled substance prescriptions over the Internet. The California investigation also discovered that between July 16 and 28, 2004, Dr. DeFrank personally issued 32 controlled substance prescriptions for Internet customers.

B&P Code §2052.5 provides authority for the Medical Board to develop a proposed registration program to be authorized for implementation by future legislation.

The Legislature has also amended B&P Code §2060:

2060. Nothing in this chapter applies to any practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state, or when an invited guest of the California Medical Association or the California Podiatric Medical Association, or one of their component county societies, or of an approved medical or podiatric medical school or college for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, if he or she is, at the time of the consultation, lecture, or demonstration a licensed physician and surgeon or a licensed doctor of podiatric medicine in the state or country in which he or she resides. **This practitioner shall not** open an office, appoint a place to meet patients, receive calls from patients within the limits of this state, give orders, or **have ultimate authority over the care or primary diagnosis of a patient who is located within this state.** [emphasis added].

Section 8 – Workforce Development and Job Creation

51. What actions has the board taken in terms of workforce development?

The Board has published and distributes a brochure *Step Into a Rewarding Career in Podiatric Medicine*, in print and online. BPM has also posted student recruitment information on its website from the American Podiatric Medical Association.

BPM provided early technical assistance and support for the establishment of a second school of podiatric medicine school in California, at Western University of Health Sciences in Pomona. As Western's first graduating class of 2013 students complete their first two years of residency training, BPM anticipates many of them will apply for DPM licensure in California. If Western eventually transitions to awarding an MD degree as it has considered, then those graduates would apply for licensure directly to the Medical Board.

52. Describe any assessment the board has conducted on the impact of licensing delays on job creation.

The Board has never permitted backlogs or delays to occur in its licensing. Licenses are issued the same day all statutory requirements are met.

53. Describe any efforts that the board takes to alleviate negative impact of its regulatory mission on California business, including small and micro business.

There are no negative impacts from BPM.

54. Describe any partnering or information sharing the board has with other government agencies, such as Workforce Investment Boards or Office of Statewide Health Planning and Development.

BPM has initiated meetings with OSHPD in the past and encouraged it to include DPMs in its studies and reports.

55. Describe the board's outreach to schools.

By law, applicants must graduate from a school approved by the Board, which accepts all schools approved by the U.S. Department of Education's designated accrediting body, the national Council on Podiatric Medical Education. The Board works particularly closely with deans, faculty and administrators of the two California-based schools. For example, the faculty of the Western University College of Podiatric Medicine is working with the UC-San Diego School of Medicine, Physician Assessment and Clinical Education (PACE) program, to design an additional Continuing Competence pathway (extended course of study) under B&P Section 2496(g) for BPM's approval.

1 56. Provide any workforce development data collected by the board, such as:

- 2 a. Workforce shortages and staffing needs
- 3 b. Successful training programs
- 4 c. Number of jobs created by its licensure program

5
6 BPM's *Step Into a Rewarding Career* quotes the U.S. Department of Labor Statistics 2008-09 *Occupational*
7 *Outlook Handbook* that "job opportunities should be good" in podiatric medicine.

8 BPM issues new licenses annually to all who apply and meet the statutory requirements: 60 in 2006/07, 55 in
9 2007/08, 47 in 2008/09, 59 in 2009/10, and 58 in 2010/11.

Section 9 – Current Issues

57. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

As a unit of the Medical Board utilizing MBC personnel for enforcement, BPM patterns enforcement procedures uniformly with “the big board.” BPM is monitoring MBC’s rulemaking to follow suit upon the Medical Board regulation becoming finalized. Staff anticipates BPM, at its September 23 meeting, will in addition to approving this *Sunset Report*, and amending its *Manual of Disciplinary Guidelines* in conformity with MBC action in regard to substance abuse standards, authorize a notice of rulemaking to enable a public hearing at BPM’s first 2012 meeting for incorporating the *Manual* revisions into its regulations by updated reference.

At BPM’s recommendation, the Joint Committee sunsetted BPM’s Diversion Program during the first Sunset Review through SB 1981 [Greene, Statutes of 1998, Chapter 736]. The Board indicated it was not aware of any evidence that state agencies administer drug and alcohol abuse programs more efficiently than the private sector. DPMs may enter private programs confidentially on their own, or be required to enroll in one as a result of BPM-imposed discipline when appropriate. BPM does not divert impaired doctors from discipline, and, as indicated in our 1997 report, saw no justification for doing so. BPM utilizes DCA-MBC service providers and standards substance-abusing probationers.

58. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

BPM was the only Board listed in the Committee’s Bill Analysis in support of SB 1111. SB 1111, the CPEI, and now SB 544 were drafted to extend to all health boards the enforcement enhancements brought to BPM and MBC by the Presley bills beginning with SB 2375 of 1990, which BPM was the first State agency to support over strong bureaucratic resistance. The emphasis was on physician discipline and that legislation was then amended to delete the allied health boards and committees at their request. It never included boards not affiliated with MBC.

BPM already has the CPEI authorities and, in consultation with DCA legal counsel, has found no new BPM regulations needed.

59. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

BPM has provided all information to the BreEZe team. It remains eager for implementation, now scheduled now for 2013.

DCA advised the Board August 17 that in addition to charging BPM (fund and budget) assessments of \$4,000 in FY 2011-12 followed in succeeding FY’s by \$11,000, \$9,000, \$8,000, \$9,000 and \$9,000 consecutively through FY 2016-17 for BreEZe SPR Funding, it projects deducting another \$15,000 annually for Credit Card BCP (BreEZe) beginning in FY 2012-13.

This unanticipated \$15,000 annual assessment is problematic.

1 DCA is assuming a two-percent transaction fee for each online renewal fee payment. Whereas the transaction
2 fee for a Registered Nurse, with a \$135 renewal fee, will be **\$2.70**, the transaction fee for each BPM renewal
3 will be **\$18.00** (two percent of the \$900 renewal fee).

4
5 With fewer than 2,000 licensees, BPM has less than 1,000 renewals each year. DCA assumes 80 percent will
6 renewal online via a credit card, i.e., 833 online renewals annually, times \$900, times two percent. That
7 calculation results in the \$15,000 that DCA projects deducting from BPM's budget annually. ***\$15,000 stands***
8 ***out as difficult to justify for 833 convenience fees***, given that BPM has the highest renewal fee and one of the
9 smallest budgets in DCA.

10
11 For two decades, BPM has kept its fund in the black by under-spending budget and returning money to its fund
12 for future use. BPM has kept its fund solvent by cutting expenditures for 20 years, developing a lean operation
13 with minimum staff.

14
15 Given the small size of BPM's budget, and the potential volatility of enforcement costs, this budget flexibility
16 has been and remains instrumental.

17
18 With BPM continuing to have the very highest renewal fee of all DCA licensees (\$900), as it has for two
19 decades, there may be little, if any, support anywhere for raising the fee. Likewise, there is no support for
20 cutting BPM's licensing or enforcement.

21
22 Deputy State and Consumer Services Agency (SCSA) Secretary for Fiscal Operations Rene Gutierrez stated
23 August 24 to DCA Budget Office staff and board executive officers that boards can implement BreEZe without
24 online payments by credit card, but they also have the option of licensees paying the convenience fee as well as
25 the renewal fee simultaneously online. It was stated that no additional legal authority is needed and that some
26 boards are already doing this.

27
28 Pursuant to this meeting with SCSA, BPM will initiate BreEze in 2013 with online renewal and the option of
29 credit card payment of the \$900 renewal fee and the \$18 credit card company convenience fee. The mail-in
30 personal check option avoiding the convenience fee will be clearly indicated, but BPM anticipates higher than
31 80 percent paying online, given the renewal fee amount.

32
33 This will cover the \$15,000 convenience fee that DCA projects deducting from BPM's budget, and ensure that
34 licensees paying by check are not in effect subsidizing those who pay online.

35
36 Most importantly, this option will help preserve BPM's fund balance.

37
38 BPM is an institution to which many have contributed much over decades. Stewardship of the BPM Special
39 Fund is key to Board Members and staff.

40
41
42 60. Describe the board's efforts to comply with OSHPD data collection efforts.

43 BPM has recommended that OSHPD data collection be conducted in a professional, controlled and uniform
44 method by its trained staff of social science survey professionals. DCA Information Services could provide
45 OSHPD licensee mailing lists, usually available in various formats. Suggestions that each board gather varied
46 data in its own fashion on renewal forms would not result in uniform, consistent or reliable data. Licensees
47 should not be obligated to complete long surveys on license renewals, and such returns could result errors and
48 exceptions where they are centrally processed outside of DCA. Increases in delayed renewals, confusion, and

1 unnecessarily delinquent licensure statuses could be expected. In BPM's case, it would also work against the
2 Continuing Competence pathway check-off, which is an appropriate renewal-form question and essential to
3 reduction of patient harm. Licensing boards do not have staff available, or trained, for collecting and tabulating
4 data for OSHPD, and no other agencies would make up the staff time lost at licensing boards working to avoid
5 backlogs.
6

7 61. Describe the board's efforts to address unlicensed activity and the underground economy.

8 The Medical Board has recently initiated action against unlicensed persons using lasers for treating medical
9 conditions on the foot: http://mbc.ca.gov/board/media/releases_2011_07-12_silberman.html
10

11 Unlicensed persons also provide orthotic devices to consumers to aid in comfort and athletic performance. And
12 they appropriately provide orthotics for medical conditions following the diagnosis and prescription by a
13 licensed doctor. BPM proposes an amendment to B&P Code Section 2477 to clarify this and to aid the Medical
14 Board and District Attorneys in responding when necessary to unlicensed practice of medicine (see below).
15

16 Unlicensed activity by persons posing as DPMs or by DPMs with invalid licenses has not been an issue in
17 recent years.
18

19 Pursuant to legislation BPM sponsored in the early 1990s (AB 1807, Statutes of 1994, chapter 26), DPM
20 licenses cancel after three years of delinquency rather than the five years still applicable for MDs. BPM
21 sponsored this provision -- B&P Code Section 2427(b) -- upon learning that prosecutors declined to file against
22 doctors practicing with delinquent licenses on the rationale such doctors would simply make up their payments
23 and delinquency fees to avoid prosecution.
24

25 Also, in the early 1990s, BPM successfully addressed through citation and fine several instances of residency
26 directors allowing podiatric medical school graduates to initiate postgraduate training prior to obtaining a
27 Residency License.
28

29 62. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis?

30 Yes

31 Is this done electronically? -- No

32 Is there a backlog? -- No

33 If so, describe the extent and efforts to address the backlog. -- N/A
34
35
36
37
38
39
40
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42
43
44

Section 10 – Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the board.
2. Short discussion of recommendations made by the Committee/Joint Committee during prior sunset review.
3. What action the board took pursuant to the recommendation or findings made under prior sunset review.
4. Any recommendations the board has for dealing with the issue.

ISSUE #1. (CONTINUE REGULATION OF THE PROFESSION AND THE BOARD?) Should the licensing and regulation of DPMs be continued, and the profession be regulated by an independent board rather than by a bureau under the Department?

Recommendation #1: *Recommend the continued regulation of DPMs by the Board of Podiatric Medicine.*

2002 Committee Comments

“... Regulation of the profession continues to be in the best interest of consumers, given the health and safety implications of podiatric medicine. Podiatrists make independent medical judgments with patients including diagnosis, prescription of medication and method of treatment. The Board continues to be an effective mechanism for licensure and oversight of podiatrists and should be continued.”

2011 PBM Comments

BPM concurs.

ISSUE #2. (INCREASE RESIDENCY TRAINING?) Should residency training be increased by one year?

Recommendation #2: *The Board should thoroughly assess the need for this additional training through an occupational analysis.*

2002 Committee Comments: Although the Board is proposing to increase the residency training requirement from one year to two years, it is unclear what educational or practical deficiency necessitates this increase.

2011 BPM Comments: The American Podiatric Medical Association (APMA) has indicated since 1995 that two-years of postgraduate residency training is the minimum required to achieve entry-level competence. The Council on Podiatric Medical Education (CPME) redesigned its residency program standards accordingly requiring two- and three-year programs. BPM provided evidence that APMA and its affiliates had conducted the requisite occupational analyses and the B&P Committees backed the two-year requirement in an amendment to B&P Code §2484 as part of AB 932 [Koretz, Statutes of 2004, Chapter 88].

ISSUE #3. (ADOPT MODEL LAW?) Should the model law as proposed by the Board be adopted?

Recommendation #3: *The DCA and the JLSRC do not have a recommendation on the Model Law which is being proposed by the BPM, but emphasize that a model law should reflect the consumer protection goals of this state.*

2002 Committee Comments: Although the Department and the Joint Committee do not yet have a position on the Model Law being proposed by the Board, any model law that is adopted must embrace the consumer protection mandate inherent in California law and not lessen or erode these standards. . . . The Board should be commended on its leadership and innovation as it looks at reforming its licensure standards. . . .

2011 BPM Comments: Many Model Law provisions were enacted with the Committee's subsequent support, following further documentation and justification, in AB 1777 [Assembly B&P, Statutes of 2003, Chapter 586] and AB 932 [Koretz, Statutes of 2004, Chapter 88]. Inter-professional association discussions are underway that may lead to further amendments.

ISSUE #4. (RENEWAL FEE?) Should the fee increase of \$100 be extended?

Recommendation #4: The fee increase should be continued for two years to ensure that the Board's fund remains solvent .

2002 Committee Comments: . . .The Board instituted a fee increase, from \$800 to \$900, effective January 1, 2000. Although the temporary fee increase is scheduled to sunset on December 31, 2003, demands on the Board's operating fund suggest continuation of the fee increase in order for the Board to maintain its current licensing and enforcement activities. The additional revenue that will be generated as a result will enable the Board's fund condition to stabilize.

2011 BPM Comments: The initial increase was enacted as a temporary measure in AB 1252 [Wildman, Statutes of 1999, Chapter 977]. SB 724 (Senate B&P Committee [Statutes of 2001, Chapter 728] extended it through calendar 2003. SB1955 [Joint Committee, Statutes of 2002, Chapter 1150] extended it through 2005. SB 1549 [Figueroa, Statutes of 2004, Chapter 691] removed the sunset clause and the fee has remained \$900, the highest in the Department, since that time. It was supported in a unanimous voice vote at the 2004 annual House of Delegates meeting of the California Podiatric Medical Association and retains consensus backing.

"CPMA and its membership have given unqualified backing to high standards and strong enforcement. Key to our members' confidence has been BPM's fairness, openness, emphasis on patient protection and quality of licensing services."

Jon A. Hultman, DPM, MBA,
Executive Director, CPMA
November 3, 2004

The decline in consumer complaints "is related to the excellent effort by the BPM to its licensees in the education, engagement, remediation and, when necessary, enforcement of the parameters regarding the quality and standard of care."

Derick Ball, DPM, President, LA Co.
Podiatric Medical Society
February 9, 2006

ISSUE #5. (CONDUCT AUDITS OF CONTINUING MEDICAL EDUCATION?) Should the Board conduct random audits of continuing medical education as it has done in the past?

Recommendation #5: *The Board should resume conducting random audits of continuing medical education (CME).*

2002 Committee Comments: Faced with fiscal challenges, the Board discontinued its contract with the Medical Board to conduct random audits of CME. These audits should resume. Board staff should begin conducting random audits of CME courses and providers to guarantee that licensees are receiving CME courses of quality and relevance to the profession. This audit function is a fundamental responsibility of the Board and must be continued.

2011 BPM Comments: BPM views the Continuing Competence requirement as paramount, but podiatric CME in California is also high quality, and BPM absolutely concurs that an annual random audit of Continuing Competency/CME compliance is a good practice.

BPM resumed the annual Continuing Competence/CME random audit in 2004. It had been delayed when BPM lost its only clerical position: the Office Technician (OT) slot was abolished for being vacant six months during a hiring freeze. BPM was finally able to reestablish this position January 1, 2005 after three years of concentrated, high-priority effort, during which time BPM's professional staff was performing the OT duties as well as their own. The Licensing Coordinator actually resumed the annual audit in 2004.

BPM recruited a new Licensing Coordinator in 2009 when the incumbent transferred elsewhere for promotion. When the Enforcement Coordinator of 17 years did the same in 2011, BPM concluded the recruitment for that position by moving the Licensing Coordinator into enforcement and hiring from another board to fill the licensing position. These transitions and the impact of furloughs on BPM's five-person staff led to another break in the audits, but the new Licensing Coordinator has initiated an audit for FY 2011-12, which should be completed by December 2011.

The annual random audit is of one percent of licensees. It verifies self-certification under penalty of perjury in the current renewal for compliance with the Continuing Competence and 50-hour CME requirements.

ISSUE #6. (REVIEW OF COMPLAINTS BY BOARD MEMBERS?) Should the members of BPM review complaints?

Recommendation #6: *Board Members should not review complaints and the Board should continue to contract with subject matter witnesses to do so.*

2002 Committee Comments: Although the Board has reduced expenditures, the Board should continue contracting with subject matter experts to review incoming complaints, and should not use Board members to perform this function. Board staff should conduct initial complaint review and forward select complaints to a panel of experts when technical expertise is needed. Board members who may ultimately vote to take action against a licensee should not be involved in the initial determination as to whether or not a complaint has merit. In spite of the cost, the Board should continue contracting out this service.

2011 BPM Comments: BPM concurs. Although it had experimented in about five cases with *pro bono* review by licensee Board Members (DPMs), who agreed to recuse themselves if the matters ever came before the

1 Board, this was terminated in 1999 prior to Joint Committee's last Sunset Review hearing on BPM December 4,
2 2001. The Board Members had agreed reluctantly, against staff recommendations, to the experiment in order to
3 accommodate one lay gubernatorial-appointee who strongly advocated this. They found it impractical. The
4 experiment ended when the DPM Board Members each refused acceptance of further cases to review.
5

6 **ISSUE #7. (TRANSITION TO A NATIONAL EXAM?) Should the Business and Professions Code be**
7 **amended to reflect a transition from the state oral clinical licensing examination to Part III of the**
8 **National Board of Podiatric Medical Examiners (NBPME) examination?**

9 **Recommendation #7:** *The statute should be amended to reflect this change in examination requirements.*

10 **2002 Committee Comments:** The Board is in the process of transitioning from the state oral exam to giving
11 Part III of the NBPME exam in its place. Business and Professions Codes Section 2486 should be amended to
12 reflect the requirement that all three parts of the NBPME exam are now required as part of licensure.
13

14 **2011 BPM Comments:** Done. SB 1955 [Figueroa, Statutes of 2002, Chapter 1150].
15

16 **ISSUE #8. (REFINE CONTINUING COMPETENCY PROGRAM?) Should BPM's continuing**
17 **competency program be amended to provide improved transition?**

18 **Recommendation #8:** *Based on the Board's experience to date, the Board's continuing competency*
19 *program should be refined to provide additional pathways and ease compliance.*
20

21 **2002 Committee Comments:** Through SB 1981, Chapter 736, Statutes of 1998, the Board initiated the first
22 continuing competence program for any doctor licensing board in this country. Under Business and Professions
23 Section 2496, each licensee must self-certify under penalty of perjury at each biennial license renewal that she
24 or he meets at least one of seven peer-review-based pathways for re-licensure. Licensees who have been
25 licensed for more than 10 years, have no peer-reviewed health facility privileges, and are not board certified,
26 must either take the BPM's licensing exam or complete a special training course sponsored by an approved
27 school under Business and Professions Code Section 2496(g). BPM has approved such a program sponsored by
28 the California College of Podiatric Medicine in conjunction with the California Podiatric Medical Association.
29 However, according to the Board, administrative transitions in both of those institutions have hampered the
30 program's development.
31

32 The Board reports that its objective has been to phase the continuing competence program in as a pilot. The
33 continuing competence requirements need to be refined based on the Board's experience to date and would
34 provide additional pathways and ease compliance for the few who lack health facility privileges and are not
35 certified by an approved specialty board.

36 These changes would ease compliance for older licensees who are neither hospital privileged nor board
37 certified. Of the seven original pathways, B&P Code Section 2496 (g) needs amendment because
38 administrative changes at the California College of Podiatric Medicine and California Podiatric Medical
39 Association hampered anticipated development of a program. The proposed eighth pathway, B&P Code
40 Section 2496 (h), would be more realistic for older licensees than the BPM's current oral clinical exam.
41

42 These changes will provide BPM an alternative to waiving the requirement or terminating the licenses of older

1 practitioners. Providing for a BPM-approved course of study and the National Boards Part III as new
2 alternatives would protect the public without forcing these older licensees out of practice for lack of a
3 reasonable pathway. As licensees become accustomed to these requirements, e.g., maintaining certification or
4 privileging, BPM anticipates tightening the pathways.

5
6 **2011 BPM Comments:** Done. B&P §2496(h) [SB 1955, Figueroa, Statutes of 2002, Chapter 1150]. Due to
7 the Joint Committee’s landmark legislation, lifelong learning has been reinforced and longitudinal complaint
8 data is showing a steady 50-percent decline. Patient harm is being prevented. While some licensees have
9 retired rather than maintain peer-reviewed skills, others have studied, taken and passed the National Boards Part
10 III Exam, testing for clinical competence at the initial licensing level. Others comply by renewing peer-
11 reviewed hospital privileging or specialty board certification.

12
13 Currently, the UC-San Diego Physician Assessment and Clinical Education (PACE) Program and the Western
14 University School of Podiatric Medicine are co-developing a program for approval under §2496(g)--“Successful
15 completion within the past five years of an extended course of study approved by the board.”

16
17 Continuing Competence has not undermined specialty certification boards or other bodies of organized
18 medicine. Rather, it has set a new, higher standard that podiatric medicine has internalized and made its own,
19 as one would expect from a privileged, elite profession.

20
21 To tighten the program, BPM amended its California Code of Regulations rules [Title 16, Division 13.9, Article
22 3, Continuing Competence] to provide for a new subsection 1399.678(e) stating “Any licensee granted a
23 temporary waiver may not be granted another temporary waiver at the next license renewal.” [Amendment with
24 new subsection (e) filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30).] This and the amended law
25 made the program more workable, enforceable, and meaningful. There is a reasonable pathway for all
26 licensees, with only a single two-year waiver possible.

Section 11 – New Issues

List new issues raised in this report. Give a short discussion of the issues, recommendations, or actions which could be taken by the board, Department of Consumer Affairs, or Legislature to deal with issues discussed in this report, i.e., legislative changes, policy direction, budget changes.

1. New issues raised by the Committee to be addressed by the board in this report.
2. New issues identified by the board that are previously addressed in this report or by prior Sunset Review. Include new proposals for legislation, policy direction or budget changes.
 - a. **B&P Section 2335(c)(2)** -- The requirement that “The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole,” effectively prevents the BPM Board Members from discussing a case in closed session as a jury even when one member of the jury identifies an issue and wishes to have discussion with her or his colleagues prior to voting. There is no such obstacle to jury deliberation in civil or criminal courts, nor was there a problem with too many cases being held by BPM prior to enactment of the two-votes rule. Deleting this, for BPM, could empower the Board as a jury and make its role more meaningful.
 - b. **B&P Section 2472(d)** -- Article 22 (Podiatric Medicine) of the Medical Practice Act has provided for a two-tier license system, depending on whether a DPM was ankle licensed “on or after January 1, 1984,” the date that the association’s ankle bill took effect to clarify this as part of the licensed scope.

Senate B&P Committee staff queried in 1997 whether this two-tiered system could be eliminated, upon receipt of BPM’s first Sunset Review report. Staff commented then it was probably premature. But now, a decade and a half later, approaching three decades since 1984, BPM would support a single scope. The useful life of the 1984 two-tier licensing has run its course.

More than 80-percent of BPM’s licensees are “ankle licensed” and this percentage is increasing monthly. It is a small number of older licensees who do not perform ankle surgery, amputations or surgical assisting to MD and DO surgeons that the “ankle license” now allows.

Doctors licensed prior to 1984 were able under the law to become ankle licensed if certified by the American Board of Podiatric Surgery (ABPS) or by passing a sophisticated, rigorous oral ankle exam administered by BPM. BPM has discontinued that exam as there is no longer any demand. Following AB 932 of 2004, there was renewed increase in taking the exam because that bill in practice disenfranchised some non-ankle-licensed doctors who had previously performed digital amputations as part of their practices to preserve diabetic limb and life. Those doctors were provided opportunities to take this “Section 2499.5(k) exam,” and most who did passed:

Exam Date	Candidate Number	Pass Rate
12/11/2004	52	75%
10/1/2005	13	73%
2/3/2007*	7	57%
2/18/2010	2	100%

Single-scope licensure would simplify the statute and its administration without harm to the public.

- c. **B&P Section 2472(f)** -- As indicated in Office of the Attorney General: Indexed Opinion No. 09-0504 - Histories & Physicals, referencing revised CMS Medicare & Medicaid Programs; Conditions of Participation (for both documents, see <http://www.bpm.ca.gov/education/healthfac.shtml#dpmsbps>), Medicare regulations no longer restrict DPM history and physical examinations. Section 2472(f) is obsolete, confusing to the public, and should be deleted.
- d. **B&P Section 2475** -- BPM proposes deleting “for up to four years,” thus sunseting the four-year cap on DPM postgraduate training. Few may participate in residency and fellowship training for more than four years, but the limit on education is unnecessary. It is the only known statutory cap on education anywhere in this country for any profession or group. It will interfere with advanced training of some leading practitioners. It is a principle of medical education that there is no such thing as too much education and training.
- e. **B&P Section 2477** -- BPM proposes amendment to clarify that anyone may offer special shoes and inserts without a license to aid comfort and athletic performance, but that a medical license is needed to diagnose and prescribe for medical conditions.
- f. **B&P Section 2493(b)** -- With the National Board of Podiatric Medical Examiners (NBPME) upgrading the national Part III licensing exam to reflect one-year of postgraduate training, in addition to graduation from podiatric medical school, BPM is recommending sunseting of Section 2493(b), which it authored as part of the negotiations leading to enactment of AB 932 of 2004. NBPME reports: “The June 2011 examination and all subsequent forms will include a board-adopted passing score that reflects entry-level competence by a podiatric physician with one year of post-graduate training.”
- g. **B&P 2497.5(b)** -- This amendment modifies §2497.5 to give the Board discretion to increase cost recovery in disciplinary cases when it non-adopts a proposed decision from an administrative law judge “and in making its own decision finds grounds for increasing the costs to be assessed.” It is unusual for the Board to non-adopt an ALJ’s proposed decision and make its own decision based on the record and new oral and written arguments. But in the event, it should not be prohibited from ordering actual and reasonable cost recovery.

§2497.5 prevents the Board from increasing cost recovery proposed by an ALJ “in any event” and also prohibits an ALJ from increasing the cost recovery when the Board remands cases. There is no apparent rationale for these provisions other than to restrict recovery of costs. This undercuts the role of the Board Members in making the final decision and has the effect of inflating licensing fees.
- h. **B&P Section 2499.5** -- Aside from BPM’s renewal fee, which accounts for more than 80 percent of the Board’s revenue, the Board’s fees for specified services have not been adjusted in two decades. The DCA Budget Office recommended in 2004, when the \$900 renewal fee was made permanent, that BPM’s other fees be adjusted to reflect actual costs of service. This was a plan combined with the renewal fee measure to stabilize the BPM special fund and rely less on further increases on the renewal fee, already the highest within DCA.

1 The following would bring fees in line with actual costs:

- 2 • Increase the application fee from \$20 to \$100
- 3 • Delete application and renewal fee discounts for recent graduates
- 4 • Add authority to waive the renewal fee for doctors working only as volunteers
- 5 consistent with MBC statute (Section 2442)
- 6 • Increase the duplicate wall certificate fee from \$40 to \$100
- 7 • Increase the duplicate renewal receipt fee from \$40 to \$50, and clarify statute to include the issuance
- 8 of pocket licenses under this provision so that it is consistent with current practice
- 9 • Increase the endorsement fee from \$30 to \$100, and clarify statute to include all of the services that
- 10 are currently provided under this subsection
- 11 • Increase the resident's license fee from \$60 to \$100
- 12 • Sunset authorization and fees for ankle licensure exam for pre-1984 licensees
- 13 • Increase the exam appeal fee from \$25 to \$100
- 14 • Increase the continuing education course approval fee from \$100 to \$250

15
16 Given BPM's close budget management and lean operation, these fees should not require further
17 adjustment for some years. While the renewal fee is the highest professional fee within the Department,
18 DPMs support it to ensure the fiscal and enforcement integrity of a board dedicated to standards
19 reflecting well on the profession.
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Section 12 – Attachments

Please provide the following attachments:

A. Board's administrative manual

BPM's administrative manual information is provided and updated online from our own webpage (About Us):

http://www.bpm.ca.gov/about_us/index.shtml

and provides additional administrative information by linking to the DCA Board Member Resource Center:

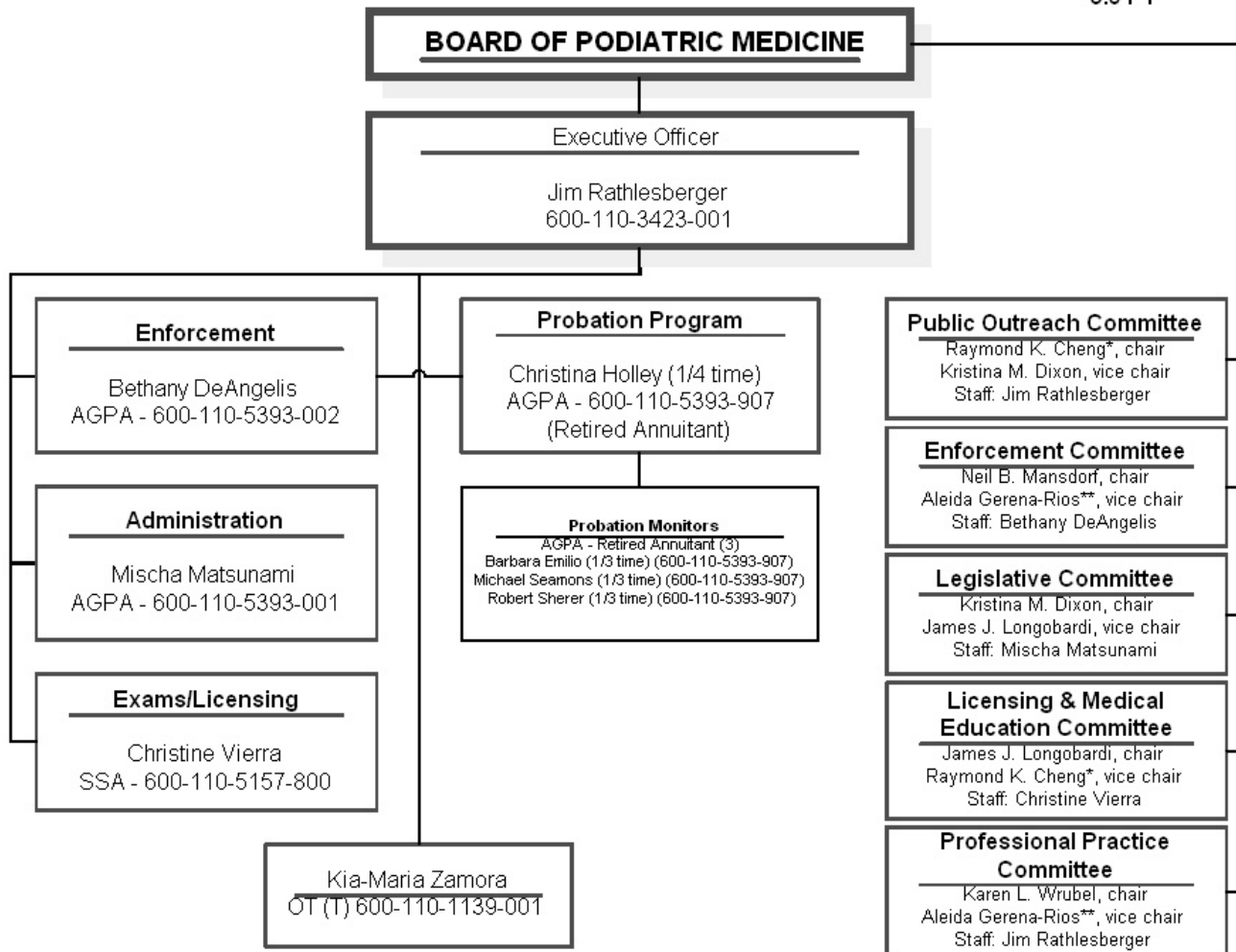
<http://www.dcaboardmembers.ca.gov/index.shtml>

With the Internet now widely used, the old paper, binder, photocopied and mailed Manual, with continual delete-and-insert updates to busy Board Members and others is an out-of-date and inefficient practice.

B. Current organizational chart showing relationship of committees to the board and membership of each committee

July 1, 2011

FY 2011-12
5.0 PY



*Grace year expired May 31, 2011

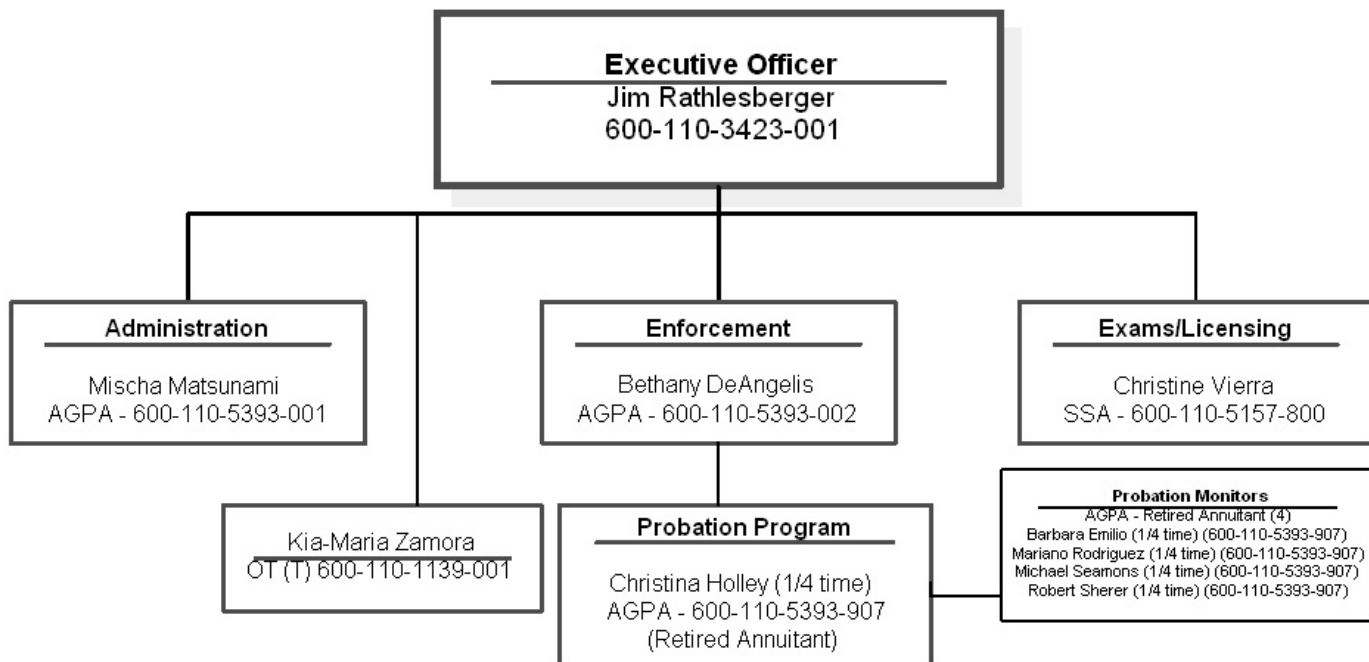
**Grace period ended June 14, 2011

C. Major studies, if appropriate -- NONE

D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.)

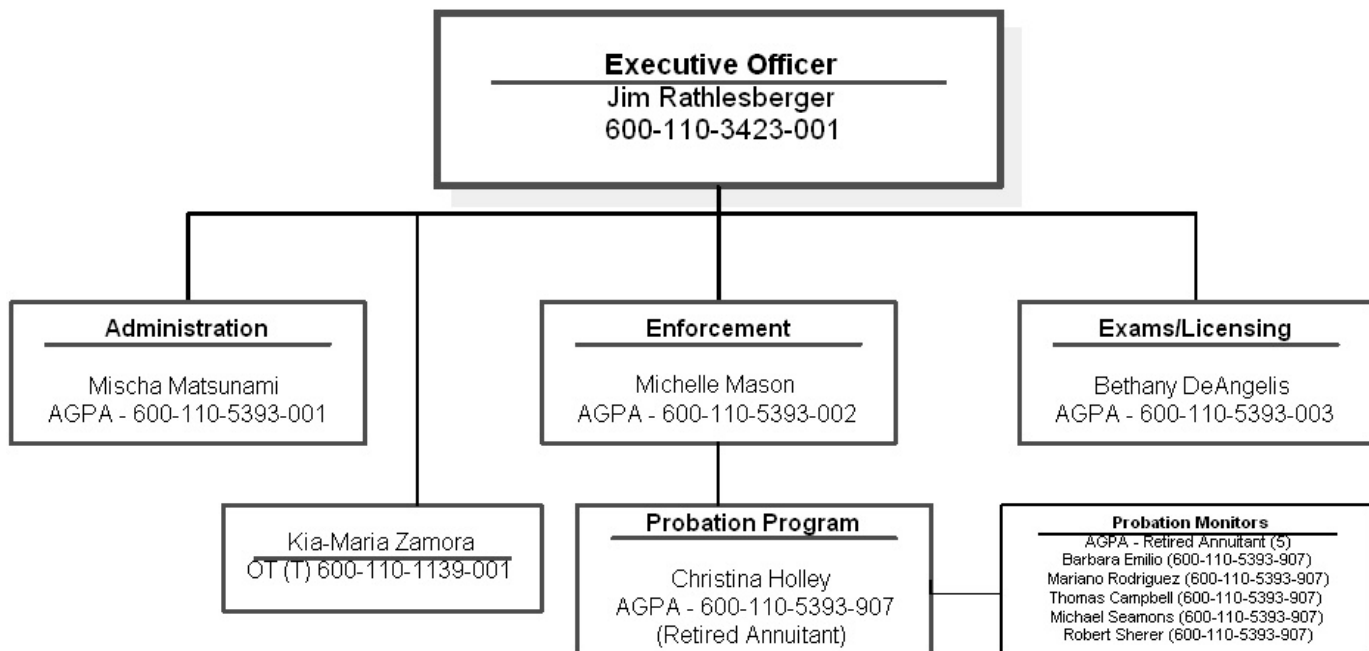
June 30, 2011

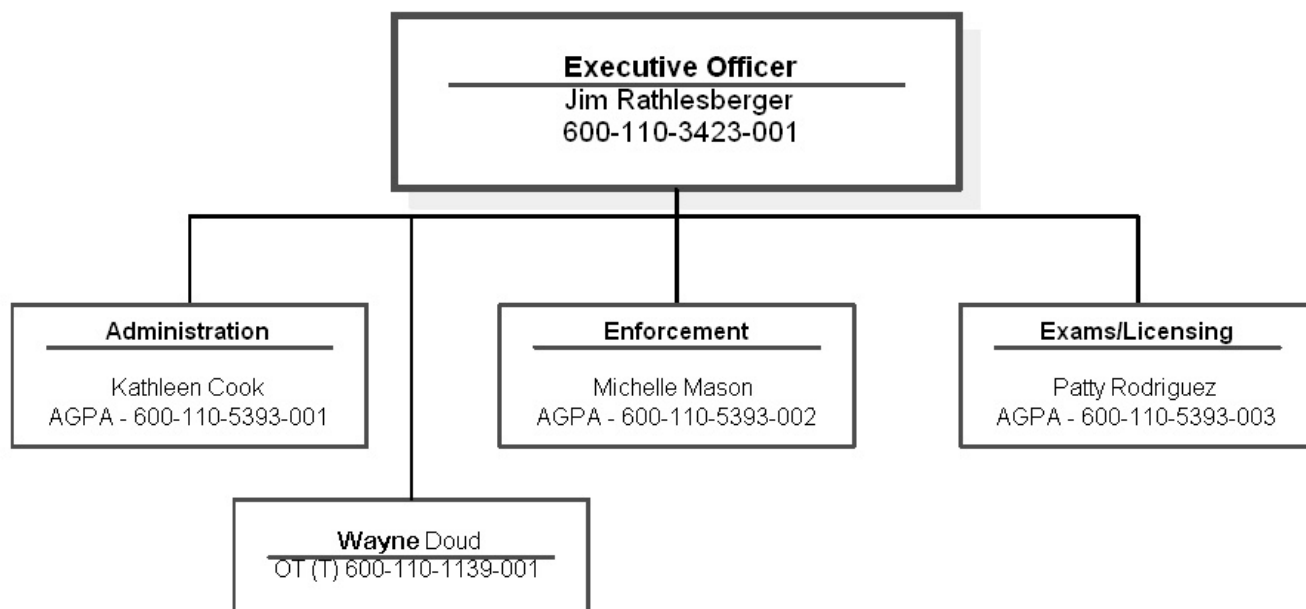
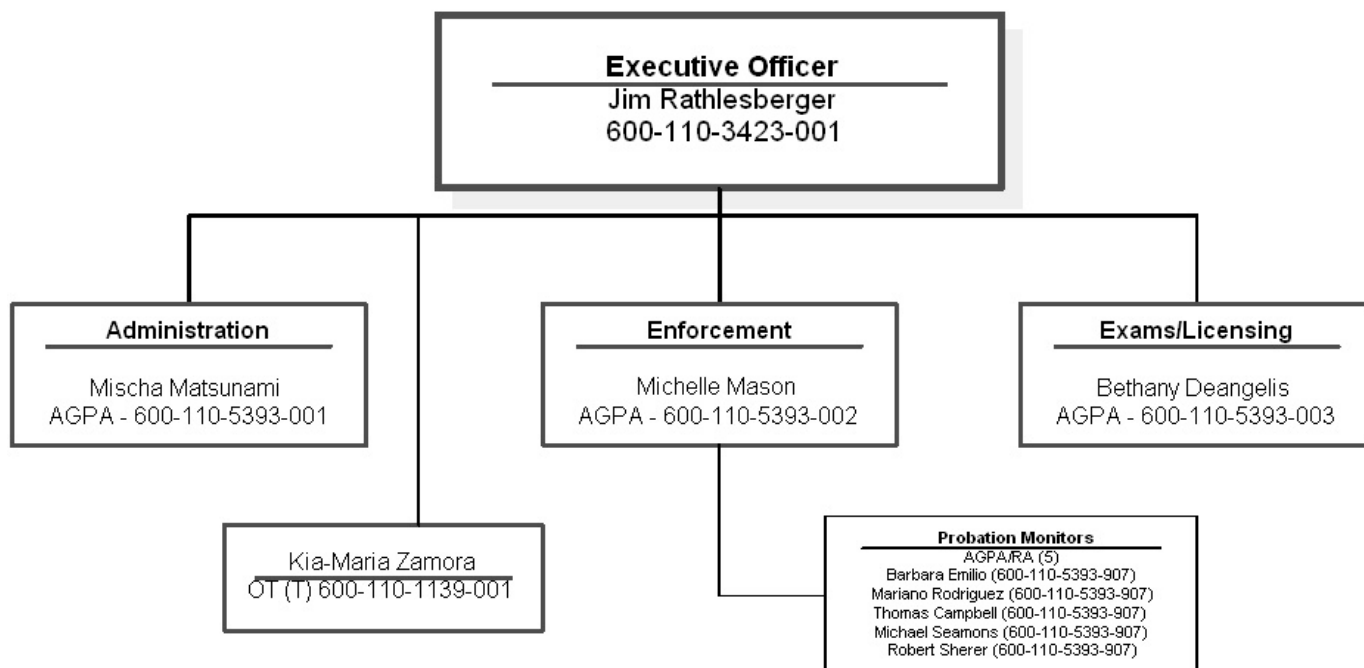
FY 2010-11
5.0 PY



June 30, 2010

FY 2009-10
5.0 PY





- 1 E. Board's records retention schedule.
- 2

STD.73 (REV. 6/2002)

RECORDS RETENTION SCHEDULE

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
STATE RECORDS PROGRAM

Submit three copies to: Department of General Services, California Records and Information Management, 707 Third St. 2nd Fl., W. Sacramento, CA 95605.

A CalRIM Consultant may be reached by phone at (916) 375-4404, by fax at (916) 375-4408 or by email at CalRIM@dgs.ca.gov

(1) DEPARTMENT, BOARD OR COMMISSION Board of Podiatric Medicine		(2) AGENCY BILLING CODE 57305	(3) PAGE 1 OF 6 PAGES	
(4) DIVISION/ BRANCH/ SECTION Dept. of Consumer Affairs		(5) ADDRESS 1420 Howe Avenue, Suite 8 Sacramento, CA. 95825		
CHECK THE APPROPRIATE BOX				
(6) <input type="checkbox"/> New schedule of records that have never been scheduled. [Complete boxes (9) - (12)]				
(7) <input checked="" type="checkbox"/> Revising a previous schedule. [Complete boxes (13) - (16)] (A new approval number will be assigned.)				
(8) <input type="checkbox"/> Amending some pages of a previous schedule. [Complete boxes (13) - (16)] (The original approval number will remain in effect.)				
NEW SCHEDULE INFORMATION (If applicable)	(9) SCHEDULE NUMBER PEC-3	(10) SCHEDULE DATE 1-16-07	(11) NUMBER OF PAGES 6	(12) CUBIC FEET (Total Schedule)
PREVIOUS SCHEDULE INFORMATION (If applicable)	(13) SCHEDULE NUMBER PEC-3	(14) APPROVAL NUMBER 00-118	(15) APPROVAL DATE (S) 02/11/2000	(16) PAGE NUMBER(S) REVISED - ALL
(17) MISSION/FUNCTIONAL STATEMENT: The mission of the Board of Podiatric Medicine is to ensure protection of consumers under the laws of California through the setting and enforcement of contemporary standards and the provision of accurate and timely information that promotes sound consumer decision-making.				
PART I - AGENCY STATEMENTS				
As the program manager (or person authorized to sign for the program manager) directly responsible for the records listed on this records retention schedule, I certify that all records listed are necessary and that each retention period is correct. For revisions, all items on the previous schedule are included or accounted for on the recapitulation. Vital records identified by this schedule are protected. If protection is not currently provided but plans are underway, the details of such plans are shown in Column 45, Remarks.				
(18) SIGNATURE - MANAGER RESPONSIBLE FOR THE RECORDS <i>Teresa Vargas</i>		(19) TITLE Executive Officer	(20) PHONE NUMBER 916-263-2650	(21) DATE SIGNED 1-16-07
In accordance with Government Code 14755, approval of this Records Retention Schedule by the Department of General Services is hereby requested. Retention periods shown have been established in accordance with the criteria set forth by Section 1667 of the State Administrative Manual.				
(22) SIGNATURE - RECORDS MGMT. ANALYST <i>Teresa Vargas</i>	(23) CLASSIFICATION RMC/SSA	(24) NAME (Printed or Typed) Teresa Vargas	(25) PHONE NUMBER 574-7260	(26) DATE SIGNED 1-16-07
PART II - DEPARTMENT OF GENERAL SERVICES APPROVAL (Per Government Code Section 14755)				
(27) SIGNATURE - CalRIM CONSULTANT <i>Janice C. Sanchez</i>		(28) APPROVAL NUMBER 07-005	(29) DATE SIGNED 1/23/2007	(30) EXPIRATION DATE 1/23/2012
PART III - ARCHIVAL SELECTION (Per Government Code Section 14755)				
THE ATTACHED RECORDS RETENTION SCHEDULE:				
(31) <input type="checkbox"/> Contains no material subject to further review by the California State Archives				
(32) <input checked="" type="checkbox"/> Contains material subject to archival review. Items stamped "NOTIFY ARCHIVES" may not be destroyed without clearance by the California State Archives. (Per Section 1671 of the State Administrative Manual.)				
(33) SIGNATURE - CHIEF OF ARCHIVES OR DESIGNATED REPRESENTATIVE <i>Johnny Bailey</i>		(34) DATE SIGNED Jan. 30, 2007		



007-005

ITEM #	CUBIC FEET *	CA. STATE ARCHIVES USE ONLY	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items)	MEDIA	VITAL	RETENTION				PRA (Exempt) & IPA (47)	REMARKS
						OFFICE	DEPT.	SRC	TOTAL		
(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)

ADMINISTRATIVE FILES											
1	1		Budget Change Proposals	P		Act +6			Act +6		Active until BCP is implemented.
2	1		Expenditures/Procurement	P		3 yrs			3 yrs		Until end of fiscal year.
3	1		Calstars Reports	P		6 yrs			6 yrs		Until end of fiscal year.
4	1		Contracts	P		Act +6			Act +6		Active until termination date of contract.
5	5		Cashiering: Claim Schedule/ROC Revenue Reports/Logs	P		2 yrs		4 yrs	6 yrs		Until end of fiscal year.
6	2	NOTIFY ARCHIVES	Meeting Agenda Packets	P		5 yrs		10 yrs	15 yrs		
7	1	NOTIFY ARCHIVES	Minutes	P		Perm			Perm		Retained permanently as historical records.
8	1		Personnel	P		Act +2			Act +2		Active until date of termination.
9	2	NOTIFY ARCHIVES	Regulatory Rulemaking Files	P		Act +5		5 yrs	Act+10		

07-005

ITEM #	CUBIC FEET *	CA. STATE ARCHIVES USE ONLY	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items)	MEDIA	VITAL	RETENTION				PRA (Exempt) & IPA	REMARKS
						OFFICE	DEPT.	SRC	TOTAL		
(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)
10	1	NOTIFY ARCHIVES	Legislation	P		Act +2		5 yrs	Act +7		
11	0.5	NOTIFY ARCHIVES	Legal Opinions	P		10 yrs		5 yrs	15 yrs		
12	0.5	NOTIFY ARCHIVES	Reports: ASP Sunset	P		Act +4		4 yrs	Act +8		
13	1		Weekly Mail Correspondence	P		4 yrs			4 yrs		Keep 4 calendar years then shred.
14	0.5		PROGRAM FILES/LICENSING Application for Licensure:	P							Licensing files are exempt from public disclosure per Public Records Act, Govt Code Sec. (6254)(c).
			Pending Completion	P		2 yrs		5 yrs	7 yrs	XI	
15	1		Failed Examination	P		3 yrs		5 yrs	8 yrs	XI	From date of failed examination.
16	3		Passed Exam/Pending Completion	P		10 yrs		5 yrs	15 yrs	XI	
17	0.5		License Denied	P		2 yrs		8 yrs	10 yrs	X	From date of denial.
18	2		Limited License Files	P		Act +5		5 yrs	Act +10	XI	Active until last expiration date.

* Provide total of office and departmental

ITEM #	CUBIC FEET *	CA. STATE ARCHIVES USE ONLY	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items)	MEDIA	VITAL	RETENTION				PRA (Exempt) & IPA	REMARKS
						OFFICE	DEPT.	SRC	TOTAL		
(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)
19	60		██████████ License Files	P		Active			Active	X I	Active until cancelled, deceased or other.
20	8		Cancelled Licenses	P		2 yrs		8 yrs	10 yrs	X I	From date of cancellation.
21	4	NOTIFY ARCHIVES	Deceased Licenses	P		1 yr		9 yrs	10 yrs	X I	From date of death.
22	2		Renewal Notices	P		2 yrs			2 yrs		Keep 2 licensing cycles then shred.
23	4		Program Files/Continuing Medical Education	P							
			Applications for Program Approval	P		5 yrs		5 yrs	10 yrs		
24	1		Program Files/Examination								Examination data used to administer licensing exams is exempt from public disclosure per Public records Act, Govt Code Sec. 6254(g)
			Candidate Audio Tapes	M		0.5 yr			0.5 yr		
25	2		Exam Question Pool	P		Active			Active	X	Active is until Exam Committee request confidential destruction.
26	3		Exam X-rays	P		Active			Active	X	

(35) CalRIM APPROVAL NUMBER

07-005

(36)

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ITEM # (37)	CUBIC FEET * (38)	CA. STATE ARCHIVES USE ONLY (39)	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items) (40)	MEDIA (41)	VITAL (42)	RETENTION				PRA (Exempt) & IPA (47)	REMARKS (48)
						OFFICE (43)	DEPT. (44)	SRC (45)	TOTAL (46)		

27	2		Exam Planning and Committee Files	P	X	3 yrs		7 yrs	10 yrs	X	
28	5.5		Program Files/Enforcement	P							
			Revoked Files	P		4 yrs			4 yrs	X	
29	1		Probation Files	P		Act +1			Act +1	X	

* Provide total of office and departmental

1
2

(35) CalRIM APPROVAL NUMBER

07-005

(36)

PAGE 6 OF 6 PAGES

ITEM #	CUBIC FEET	CA. STATE ARCHIVES USE ONLY	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items)	MEDIA	VITAL	RETENTION				PRA (Exempt) & IPA	REMARKS
						OFFICE	DEPT.	SRC	TOTAL		
(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)

<u>Records Management</u>											
30.			STD Form 70, Records Inventory Worksheet	P		Current			Current		Retain as current until next inventory, or when no longer needed for reference or analysis, whichever is later.
31.			STD Form 71, Records Transfer List	P		Current			Current		Retain as current until all records have been either destroyed, retired permanently, transferred to the State Archives, or when no longer needed whichever is later.
32.			STD Form 73, Records Retention Schedule	P		Current			Current		Retain as current until revised. NOTE: Although revision is required every five years from date approved by CalRIM, records retention schedules that are not revised remain in effect but are considered non-current.
33.			Authorization for Records Destruction (Computer Printouts)	P		4			4		Retain for two years from date destruction is authorized. Then retain two additional years or until audited, whichever occurs first (maximum of four years).
34.			Electronic Mail A. E-mail that are categorized as official records are subject to department records retention schedule and must be retained for the same period of time as the records series that most closely matches the subject matter contained within the new e-message. If there is no entry that resembles or matches the subject matter of the e-message, the "record" should be added to the schedule as a separate series (separate item number). B. Transitory e-Mail consists of electronic messages that are created primarily for the communication of informal information as opposed to the perpetuation or formalization of knowledge.	M		* 90 Days	*	*	* 90 Days		"E-mail communications that have "official records status" are subject to department records retention schedule and must be retained for the same period of time as the records series that most closely matches the subject matter of the e-communication in question. Destroy transitory e-communications when they have served their purpose.

1
2 F. Board's proposed legislative changes to B&P Code, Division 2 (Healing Arts), Chapter 5
3 (Medicine), Article 22 (Podiatric Medicine):
4

5 BUSINESS AND PROFESSIONS CODE

6 SECTION 2460-2499.8

7
8

9 2460. (a) There is created within the jurisdiction of the Medical
10 Board of California the California Board of Podiatric Medicine.

11 (b) This section shall remain in effect only until January 1,
12 2013, and as of that date is repealed, unless a later enacted
13 statute, that is enacted before January 1, 2013, deletes or extends
14 that date. The repeal of this section renders the California Board of
15 Podiatric Medicine subject to the review required by Division 1.2
16 (commencing with Section 473).
17

18
19 2460.1. Protection of the public shall be the highest priority for
20 the California Board of Podiatric Medicine in exercising its
21 licensing, regulatory, and disciplinary functions. Whenever the
22 protection of the public is inconsistent with other interests sought
23 to be promoted, the protection of the public shall be paramount.
24
25

26 2461. As used in this article:

27 (a) "Division" means the Division of Licensing of the Medical
28 Board of California.

29 (b) "Board" means the California Board of Podiatric Medicine.

30 (c) "Podiatric licensing authority" refers to any officer, board,
31 commission, committee, or department of another state that may issue
32 a license to practice podiatric medicine.
33
34

35 2462. The board shall consist of seven members, three of whom shall
36 be public members. Not more than one member of the board shall be a
37 full-time faculty member of a college or school of podiatric
38 medicine.

39 The Governor shall appoint the four members qualified as provided
40 in Section 2463 and one public member. The Senate Rules Committee and
41 the Speaker of the Assembly shall each appoint a public member.
42
43

44 2463. Each member of the board, except the public members, shall be
45 appointed from persons having all of the following qualifications:

46 (a) Be a citizen of this state for at least five years next
47 preceding his or her appointment.

48 (b) Be a graduate of a recognized school or college of podiatric
49 medicine.

50 (c) Have a valid certificate to practice podiatric medicine in
51 this state.

52 (d) Have engaged in the practice of podiatric medicine in this
53 state for at least five years next preceding his or her appointment.
54

55 2464. The public members shall be appointed from persons having all
56 of the following qualifications:

1 (a) Be a citizen of this state for at least five years next
2 preceding his or her appointment.

3 (b) Shall not be an officer or faculty member of any college,
4 school, or other institution engaged in podiatric medical
5 instruction.

6 (c) Shall not be a licentiate of the board or of any board under
7 this division or of any board created by an initiative act under this
8 division.
9

10 2465. No person who directly or indirectly owns any interest in any
11 college, school, or other institution engaged in podiatric medical
12 instruction shall be appointed to the board **nor** shall any incumbent
13 member of the board have or acquire any interest, direct or indirect,
14 in any such college, school, or institution.
15
16

17 2466. All members of the board shall be appointed for terms of four
18 years. Vacancies shall immediately be filled by the appointing power
19 for the unexpired portion of the terms in which they occur. No
20 person shall serve as a member of the board for more than two
21 consecutive terms.
22
23

24 2467. (a) The board may convene from time to time as it deems
25 necessary.
26

27 (b) Four members of the board constitute a quorum for the
28 transaction of business at any meeting.

29 (c) It shall require the affirmative vote of a majority of those
30 members present at a meeting, those members constituting at least a
31 quorum, to pass any motion, resolution, or measure.

32 (d) The board shall annually elect one of its members to act as
33 president and a member to act as vice president who shall hold their
34 respective positions at the pleasure of the board. The president may
35 call meetings of the board and any duly appointed committee at a
36 specified time and place.
37
38

39 2468. Notice of each meeting of the board shall be given in
40 accordance with the Bagley-Keene Open Meeting Act (Article 9
41 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3
42 of Title 2 of the Government Code).
43
44

45 2469. Each member of the board shall receive per diem and expenses
46 as provided in Section 2016.
47
48

49 2470. The board may adopt, amend, or repeal, in accordance with the
50 provisions of the Administrative Procedure Act, regulations
51 necessary to enable the board to carry into effect the provisions of
52 law relating to the practice of podiatric medicine.
53
54

55 2471. Except as provided by Section 159.5, the board may employ,
56 within the limits of the funds received by the board, all personnel
57 necessary to carry out this chapter.

58 2472. (a) The certificate to practice podiatric medicine authorizes
59 the holder to practice podiatric medicine.

1 (b) As used in this chapter, "podiatric medicine" means the
2 diagnosis, medical, surgical, mechanical, manipulative, and
3 electrical treatment of the human foot, including the ankle and
4 tendons that insert into the foot and the nonsurgical treatment of
5 the muscles and tendons of the leg governing the functions of the
6 foot.

7 (c) A doctor of podiatric medicine may not administer an
8 anesthetic other than local. If an anesthetic other than local is
9 required for any procedure, the anesthetic shall be administered by
10 another licensed health care practitioner who is authorized to
11 administer the required anesthetic within the scope of his or her
12 practice.

13 (d) (1) A doctor of podiatric medicine ~~who is ankle certified by~~
14 ~~the board on and after January 1, 1984,~~ may do the following:

15 (A) Perform surgical treatment of the ankle and tendons at the
16 level of the ankle pursuant to subdivision (e).

17 (B) Perform services under the direct supervision of a physician
18 and surgeon, as an assistant at surgery, in surgical procedures that
19 are otherwise beyond the scope of practice of a doctor of podiatric
20 medicine.

21 (C) Perform a partial amputation of the foot no further proximal
22 than the Chopart's joint.

23 (2) Nothing in this subdivision shall be construed to permit a
24 doctor of podiatric medicine to function as a primary surgeon for any
25 procedure beyond his or her scope of practice.

26 (e) A doctor of podiatric medicine may perform surgical treatment
27 of the ankle and tendons at the level of the ankle only in the
28 following locations:

29 (1) A licensed general acute care hospital, as defined in Section
30 1250 of the Health and Safety Code.

31 (2) A licensed surgical clinic, as defined in Section 1204 of the
32 Health and Safety Code, if the doctor of podiatric medicine has
33 surgical privileges, including the privilege to perform surgery on
34 the ankle, in a general acute care hospital described in paragraph
35 (1) and meets all the protocols of the surgical clinic.

36 (3) An ambulatory surgical center that is certified to participate
37 in the Medicare Program under Title XVIII (42 U.S.C. Sec. 1395 et
38 seq.) of the federal Social Security Act, if the doctor of podiatric
39 medicine has surgical privileges, including the privilege to perform
40 surgery on the ankle, in a general acute care hospital described in
41 paragraph (1) and meets all the protocols of the surgical center.

42 (4) A freestanding physical plant housing outpatient services of a
43 licensed general acute care hospital, as defined in Section 1250 of
44 the Health and Safety Code, if the doctor of podiatric medicine has
45 surgical privileges, including the privilege to perform surgery on
46 the ankle, in a general acute care hospital described in paragraph
47 (1). For purposes of this section, a "freestanding physical plant"
48 means any building that is not physically attached to a building
49 where inpatient services are provided.

50 (5) An outpatient setting accredited pursuant to subdivision (g)
51 of Section 1248.1 of the Health and Safety Code.

52 ~~(f) A doctor of podiatric medicine shall not perform an admitting~~
53 ~~history and physical examination of a patient in an acute care~~
54 ~~hospital where doing so would violate the regulations governing the~~
55 ~~Medicare program.~~

56 ~~(g) A doctor of podiatric medicine licensed under this chapter is~~
57 ~~a licentiate for purposes of paragraph (2) of subdivision (a) of~~
58 ~~Section 805, and thus is a health care practitioner subject to the~~
59 ~~provisions of Section 2290.5 pursuant to subdivision (b) of that~~

1 ~~section.~~ [Duplicative--covered by Section 805(a)(2)itself]
2
3

4 2474. Any person who uses in any sign or in any advertisement or
5 otherwise, the word or words "doctor of podiatric medicine," "doctor
6 of podiatry," "podiatric doctor," "D.P.M.," "podiatrist," "foot
7 specialist," or any other term or terms or any letters indicating or
8 implying that he or she is a doctor of podiatric medicine, or that he
9 or she practices podiatric medicine, or holds himself out as
10 practicing podiatric medicine or foot correction as defined in
11 Section 2472, without having at the time of so doing a valid,
12 unrevoked, and unsuspended certificate as provided for in this
13 chapter, is guilty of a misdemeanor.
14
15

16 2475. Unless otherwise provided by law, no postgraduate trainee,
17 intern, resident postdoctoral fellow, or instructor may engage in the
18 practice of podiatric medicine, or receive compensation therefor, or
19 offer to engage in the practice of podiatric medicine unless he or
20 she holds a valid, unrevoked, and unsuspended certificate to practice
21 podiatric medicine issued by the division. However, a graduate of an
22 approved college or school of podiatric medicine upon whom the
23 degree doctor of podiatric medicine has been conferred, who is issued
24 a resident's license, which may be renewed annually ~~for up to four~~
25 ~~years~~ for this purpose by the division upon recommendation of the
26 board, and who is enrolled in a postgraduate training program
27 approved by the board, may engage in the practice of podiatric
28 medicine whenever and wherever required as a part of that program and
29 may receive compensation for that practice under the following
30 conditions:

31 (a) A graduate with a resident's license in an approved
32 internship, residency, or fellowship program may participate in
33 training rotations outside the scope of podiatric medicine, under the
34 supervision of a physician and surgeon who holds a medical doctor or
35 doctor of osteopathy degree wherever and whenever required as a part
36 of the training program, and may receive compensation for that
37 practice. If the graduate fails to receive a license to practice
38 podiatric medicine under this chapter within three years from the
39 commencement of the postgraduate training, all privileges and
40 exemptions under this section shall automatically cease.

41 (b) Hospitals functioning as a part of the teaching program of an
42 approved college or school of podiatric medicine in this state may
43 exchange instructors or resident or assistant resident doctors of
44 podiatric medicine with another approved college or school of
45 podiatric medicine not located in this state, or those hospitals may
46 appoint a graduate of an approved school as such a resident for
47 purposes of postgraduate training. Those instructors and residents
48 may practice and be compensated as provided in this section, but that
49 practice and compensation shall be for a period not to exceed two
50 years.
51
52

53 2475.1. Before a resident's license may be issued, each applicant
54 shall show by evidence satisfactory to the board, submitted directly
55 to the board by the national score reporting institution, that he or
56 she has, within the past 10 years, passed Parts I and II of the
57 examination administered by the National Board of Podiatric Medical
58 Examiners of the United States or has passed a written examination
59 that is recognized by the board to be the equivalent in content to
60 the examination administered by the National Board of Podiatric

1 Medical Examiners of the United States.

2
3
4 2475.2. As used in this article, "podiatric residency" means a
5 program of supervised postgraduate clinical training, one year or
6 more in duration, approved by the board.
7

8
9 2475.3. (a) The board shall approve podiatric residency programs,
10 as defined in Section 2475.2, in the field of podiatric medicine, for
11 persons who are applicants for or have been issued a certificate to
12 practice podiatric medicine pursuant to this article.

13 (b) The board may only approve a podiatric residency that it
14 determines meets all of the following requirements:

15 (1) Reasonably conforms with the Accreditation Council for
16 Graduate Medical Education's Institutional Requirements of the
17 Essentials of Accredited Residencies in Graduate Medical Education:
18 Institutional and Program Requirements.

19 (2) Is approved by the Council on Podiatric Medical Education.

20 (3) Complies with the requirements of this state.
21
22

23 2476. Nothing in this chapter shall be construed to prevent a
24 regularly matriculated student undertaking a course of professional
25 instruction in an approved college or school of podiatric medicine
26 from participating in training beyond the scope of podiatric medicine
27 under the supervision of a physician and surgeon who holds a medical
28 doctor or doctor of osteopathy degree whenever and wherever
29 prescribed as part of his or her course of study.
30
31

32 2477. Nothing in this chapter prohibits the manufacture, the
33 recommendation, or the sale of either corrective shoes or appliances
34 for the human feet to enhance comfort and performance, or, following
35 diagnosis and prescription by a licensed practitioner, in any case
36 involving medical conditions.
37
38

39 2479. The division shall issue, upon the recommendation of the
40 board, a certificate to practice podiatric medicine to each applicant
41 who meets the requirements of this chapter. Every applicant for a
42 certificate to practice podiatric medicine shall comply with the
43 provisions of Article 4 (commencing with Section 2080) which are not
44 specifically applicable to applicants for a physician's and surgeon's
45 certificate, in addition to the provisions of this article.
46
47

48 2480. The board shall have full authority to investigate and to
49 evaluate each applicant applying for a certificate to practice
50 podiatric medicine and to make a determination of the admission of
51 the applicant to the examination and the issuance of a certificate in
52 accordance with the provisions and requirements of this chapter.
53
54
55

56 2481. Each applicant who commenced professional instruction in
57 podiatric medicine after September 1, 1959, shall show by an official
58 transcript or other official evidence submitted directly to the
59 board by the academic institution that he or she has completed two

1 years of preprofessional postsecondary education, or its equivalent,
2 including the subjects of chemistry, biology or other biological
3 science, and physics or mathematics, before completing the resident
4 course of professional instruction.
5
6

7 2483. (a) Each applicant for a certificate to practice podiatric
8 medicine shall show by an official transcript or other official
9 evidence satisfactory to the board that is submitted directly to the
10 board by the academic institution that he or she has successfully
11 completed a medical curriculum extending over a period of at least
12 four academic years, or 32 months of actual instruction, in a college
13 or school of podiatric medicine approved by the board. The total
14 number of hours of all courses shall consist of a minimum of 4,000
15 hours.

16 The board, by regulation, shall adopt standards for determining
17 equivalent training authorized by this section.

18 (b) The curriculum for all applicants shall provide for adequate
19 instruction related to podiatric medicine in the following:

20 Alcoholism and other chemical substance detection
21 Local anesthesia
22 Anatomy, including embryology, histology, and neuroanatomy
23 Behavioral science
24 Biochemistry
25 Biomechanics-foot and ankle
26 Child abuse detection
27 Dermatology
28 Geriatric medicine
29 Human sexuality
30 Infectious diseases
31 Medical ethics
32 Neurology
33 Orthopedic surgery
34 Pathology, microbiology, and immunology
35 Pediatrics
36 Pharmacology, including materia medica and toxicology
37 Physical and laboratory diagnosis
38 Physical medicine
39 Physiology
40 Podiatric medicine
41 Podiatric surgery
42 Preventive medicine, including nutrition
43 Psychiatric problem detection
44 Radiology and radiation safety
45 Spousal or partner abuse detection
46 Therapeutics
47 Women's health
48
49

50 2484. In addition to any other requirements of this chapter, before
51 a certificate to practice podiatric medicine may be issued, each
52 applicant shall show by evidence satisfactory to the board, submitted
53 directly to the board by the sponsoring institution, that he or she
54 has satisfactorily completed at least two years of postgraduate
55 podiatric medical and podiatric surgical training in a general acute
56 care hospital approved by the Council ~~of~~ on Podiatric Medical Education.

57 2486. The Medical Board of California shall issue, upon the
58 recommendation of the board, a certificate to practice podiatric
59 medicine if the applicant has submitted directly to the board from

1 the credentialing organizations verification that he or she meets all
2 of the following requirements:

3 (a) The applicant has graduated from an approved school or college
4 of podiatric medicine and meets the requirements of Section 2483.

5 (b) The applicant, within the past 10 years, has passed parts I,
6 II, and III of the examination administered by the National Board of
7 Podiatric Medical Examiners of the United States or has passed a
8 written examination that is recognized by the board to be the
9 equivalent in content to the examination administered by the National
10 Board of Podiatric Medical Examiners of the United States.

11 (c) The applicant has satisfactorily completed the postgraduate
12 training required by Section 2484.

13 (d) The applicant has passed within the past 10 years any oral and
14 practical examination that may be required of all applicants by the
15 board to ascertain clinical competence.

16 (e) The applicant has committed no acts or crimes constituting
17 grounds for denial of a certificate under Division 1.5 (commencing
18 with Section 475).

19 (f) The board determines that no disciplinary action has been
20 taken against the applicant by any podiatric licensing authority and
21 that the applicant has not been the subject of adverse judgments or
22 settlements resulting from the practice of podiatric medicine that
23 the board determines constitutes evidence of a pattern of negligence
24 or incompetence.

25 (g) A disciplinary databank report regarding the applicant is
26 received by the board from the Federation of Podiatric Medical
27 Boards.

28
29
30 2488. Notwithstanding any other provision of law, the Medical Board
31 of California shall issue, upon the recommendation of the board, a
32 certificate to practice podiatric medicine by credentialing if the
33 applicant has submitted directly to the board from the credentialing
34 organizations verification that he or she is licensed as a doctor of
35 podiatric medicine in any other state and meets all of the following
36 requirements:

37 (a) The applicant has graduated from an approved school or college
38 of podiatric medicine.

39 (b) The applicant, within the past 10 years, has passed either
40 part III of the examination administered by the National Board of
41 Podiatric Medical Examiners of the United States or a written
42 examination that is recognized by the board to be the equivalent in
43 content to the examination administered by the National Board of
44 Podiatric Medical Examiners of the United States.

45 (c) The applicant has satisfactorily completed a postgraduate
46 training program approved by the Council on Podiatric Medical
47 Education.

48 (d) The applicant, within the past 10 years, has passed any oral
49 and practical examination that may be required of all applicants by
50 the board to ascertain clinical competence.

51 (e) The applicant has committed no acts or crimes constituting
52 grounds for denial of a certificate under Division 1.5 (commencing
53 with Section 475).

54 (f) The board determines that no disciplinary action has been
55 taken against the applicant by any podiatric licensing authority and
56 that the applicant has not been the subject of adverse judgments or
57 settlements resulting from the practice of podiatric medicine that
58 the board determines constitutes evidence of a pattern of negligence
59 or incompetence.

1 (g) A disciplinary databank report regarding the applicant is
2 received by the board from the Federation of Podiatric Medical
3 Boards.
4
5

6 2492. (a) The board shall examine every applicant for a certificate
7 to practice podiatric medicine to ensure a minimum of entry-level
8 competence at the time and place designated by the board in its
9 discretion, but at least twice a year.

10 (b) Unless the applicant meets the requirements of Section 2486,
11 applicants shall be required to have taken and passed the examination
12 administered by the National Board of Podiatric Medical Examiners.

13 (c) The board may appoint qualified persons to give the whole or
14 any portion of any examination as provided in this article, who shall
15 be designated as examination commissioners. The board may fix the
16 compensation of those persons subject to the provisions of applicable
17 state laws and regulations.

18 (d) The provisions of Article 9 (commencing with Section 2170)
19 shall apply to examinations administered by the board except where
20 those provisions are in conflict with or inconsistent with the
21 provisions of this article. In respect to applicants under this
22 article any references to the "Division of Licensing" or "division"
23 shall be deemed to apply to the board.
24
25

26 2493. (a) An applicant for a certificate to practice podiatric
27 medicine shall pass an examination in the subjects required by
28 Section 2483 in order to ensure a minimum of entry-level competence.

29 ~~(b) The board shall require a passing score on the National Board~~
30 ~~of Podiatric Medical Examiners Part III examination that is~~
31 ~~consistent with the postgraduate training requirement in Section~~
32 ~~2484. The board, as of July 1, 2005, shall require a passing score~~
33 ~~one standard error of measurement higher than the national passing~~
34 ~~scale score until such time as the National Board of Podiatric~~
35 ~~Medical Examiners recommends a higher passing score consistent with~~
36 ~~Section 2484. In consultation with the Office of Professional~~
37 ~~Examination Services of the Department of Consumer Affairs, the board~~
38 ~~shall ensure that the part III examination adequately evaluates the~~
39 ~~full scope of practice established by Section 2472, including~~
40 ~~amputation and other foot and ankle surgical procedures, pursuant to~~
41 ~~Section 139.~~
42
43

44 2495. Notwithstanding any other provision of this chapter, the
45 board may delegate to officials of the board the authority to approve
46 the admission of applicants to the examination and to approve the
47 issuance of certificates to practice podiatric medicine to applicants
48 who have met the specific requirements therefor in routine cases
49 where applicants clearly meet the requirements of this chapter.
50
51

52 2496. In order to ensure the continuing competence of persons
53 licensed to practice podiatric medicine, the board shall adopt and
54 administer regulations ~~in accordance with the Administrative~~
55 ~~Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1~~
56 ~~of Division 3 of Title 2 of the Government Code)~~
57 ~~[Duplicates Section 2470 and other statutes]~~
58 requiring continuing education of those licensees. The board shall require those
59 licensees to demonstrate satisfaction of the continuing education

1 requirements and one of the following requirements at each license
2 renewal:

3 (a) Passage of an examination administered by the board within the
4 past 10 years.

5 (b) Passage of an examination administered by an approved
6 specialty certifying board within the past 10 years.

7 (c) Current diplomate, board-eligible, or board-qualified status
8 granted by an approved specialty certifying board within the past 10
9 years.

10 (d) Recertification of current status by an approved specialty
11 certifying board within the past 10 years.

12 (e) Successful completion of an approved residency or fellowship
13 program within the past 10 years.

14 (f) Granting or renewal of current staff privileges within the
15 past five years by a health care facility that is licensed,
16 certified, accredited, conducted, maintained, operated, or otherwise
17 approved by an agency of the federal or state government or an
18 organization approved by the Medical Board of California.

19 (g) Successful completion within the past five years of an
20 extended course of study approved by the board.

21 (h) Passage within the past 10 years of Part III of the
22 examination administered by the National Board of Podiatric Medical
23 Examiners.
24
25

26 2497. (a) The board may order the denial of an application for, or
27 the suspension of, or the revocation of, or the imposition of
28 probationary conditions upon, a certificate to practice podiatric
29 medicine for any of the causes set forth in Article 12 (commencing
30 with Section 2220) in accordance with Section 2222.

31 (b) The board may hear all matters, including but not limited to,
32 any contested case or may assign any such matters to an
33 administrative law judge. The proceedings shall be held in accordance
34 with Section 2230. If a contested case is heard by the board itself,
35 the administrative law judge who presided at the hearing shall be
36 present during the board's consideration of the case and shall assist
37 and advise the board.
38
39

40 2497.5. (a) The board may request the administrative law judge,
41 under his or her proposed decision in resolution of a disciplinary
42 proceeding before the board, to direct any licensee found guilty of
43 unprofessional conduct to pay to the board a sum not to exceed the
44 actual and reasonable costs of the investigation and prosecution of
45 the case.

46 (b) The costs to be assessed shall be fixed by the administrative law
47 judge and shall not in any event be increased by the board unless the board
48 does not adopt a proposed decision and in making its own decision finds
49 grounds for increasing the costs to be assessed. When the board does not
50 adopt a proposed decision and remands the case to an administrative law
51 judge, the administrative law judge shall not increase the amount of any
52 costs assessed in the proposed decision.

53 (c) When the payment directed in the board's order for payment of
54 costs is not made by the licensee, the board may enforce the order
55 for payment by bringing an action in any appropriate court. This
56 right of enforcement shall be in addition to any other rights the
57 board may have as to any licensee directed to pay costs.

58 (d) In any judicial action for the recovery of costs, proof of the
59 board's decision shall be conclusive proof of the validity of the
60 order of payment and the terms for payment.

1 (e) (1) Except as provided in paragraph (2), the board shall not
2 renew or reinstate the license of any licensee who has failed to pay
3 all of the costs ordered under this section.

4 (2) Notwithstanding paragraph (1), the board may, in its
5 discretion, conditionally renew or reinstate for a maximum of one
6 year the license of any licensee who demonstrates financial hardship
7 and who enters into a formal agreement with the board to reimburse
8 the board within that one year period for those unpaid costs.

9 (f) All costs recovered under this section shall be deposited in
10 the Board of Podiatric Medicine Fund as a reimbursement in either the
11 fiscal year in which the costs are actually recovered or the
12 previous fiscal year, as the board may direct.
13
14

15 2498. (a) The board shall have the responsibility for reviewing the
16 quality of podiatric medical practice carried out by persons
17 licensed to practice podiatric medicine.

18 (b) Each member of the board, or any licensed doctor of podiatric
19 medicine appointed by the board, shall additionally have the
20 authority to inspect, or require reports from, a general or
21 specialized hospital and the podiatric medical staff thereof, with
22 respect to the podiatric medical care, services, or facilities
23 provided therein, and may inspect podiatric medical patient records
24 with respect to the care, services, or facilities. The authority to
25 make inspections and to require reports as provided by this section
26 shall not be delegated by a member of the board to any person other
27 than a doctor of podiatric medicine and shall be subject to the
28 restrictions against disclosure described in Section 2263.
29
30

31 2499. There is in the State Treasury the Board of Podiatric
32 Medicine Fund. Notwithstanding Section 2445, the division shall
33 report to the Controller at the beginning of each calendar month for
34 the month preceding the amount and source of all revenue received by
35 it on behalf of the board, pursuant to this chapter, and shall pay
36 the entire amount thereof to the Treasurer for deposit into the fund.
37 All revenue received by the board and the division from fees
38 authorized to be charged relating to the practice of podiatric
39 medicine shall be deposited in the fund as provided in this section,
40 and shall be used to carry out the provisions of this chapter
41 relating to the regulation of the practice of podiatric medicine.
42
43

44 2499.5. The following fees apply to certificates to practice
45 podiatric medicine. The amount of fees prescribed for doctors of
46 podiatric medicine shall be those set forth in this section unless a
47 lower fee is established by the board in accordance with Section
48 2499.6. Fees collected pursuant to this section shall be fixed by the
49 board in amounts not to exceed the actual costs of providing the
50 service for which the fee is collected.

51 (a) Each applicant for a certificate to practice podiatric
52 medicine shall pay an application fee of twenty one hundred
53 dollars ~~(\$20)~~ (\$100) at the
54 time the application is filed. If the applicant qualifies for a
55 certificate, he or she shall pay a fee which shall be fixed by the
56 board at an amount not to exceed one hundred dollars (\$100) nor less
57 than five dollars (\$5) for the issuance of the certificate.

58 (b) The oral examination fee shall be seven hundred dollars
59 (\$700), or the actual cost, whichever is lower, and shall be paid by

1 each applicant. If the applicant's credentials are insufficient or if
2 the applicant does not desire to take the examination, and has so
3 notified the board 30 days prior to the examination date, only the
4 examination fee is returnable to the applicant. The board may charge
5 an examination fee for any subsequent reexamination of the applicant.

6 (c) Each applicant who qualifies for a certificate, as a condition
7 precedent to its issuance, in addition to other fees required by
8 this section, shall pay an initial license fee. The initial license
9 fee shall be eight hundred dollars (\$800). The initial license shall
10 expire the second year after its issuance on the last day of the
11 month of birth of the licensee. ~~The board may reduce the initial~~
12 ~~license fee by up to 50 percent of the amount of the fee for any~~
13 ~~applicant who is enrolled in a postgraduate training program approved~~
14 ~~by the board or who has completed a postgraduate training program~~
15 ~~approved by the board within six months prior to the payment of the~~
16 ~~initial license fee.~~

17 (d) The biennial renewal fee shall be nine hundred dollars (\$900).
18 ~~Any licensee enrolled in an approved residency program shall be~~
19 ~~required to pay only 50 percent of the biennial renewal fee at the~~
20 ~~time of his or her first renewal. The board may waive this fee for a doctor of~~
21 ~~podiatric medicine residing in California who certifies to the board that license~~
22 ~~renewal is for the sole purpose of providing voluntary, unpaid service.~~

23 (e) The delinquency fee is one hundred fifty dollars (\$150).

24 (f) The duplicate wall certificate fee is ~~forty~~ one hundred dollars ~~(\$40)~~ \$100.

25 (g) The ~~fee for a~~ duplicate renewal receipt ~~fee or pocket license~~ is ~~forty fifty~~
26 dollars ~~(\$40)~~ (\$50).

27 (h) The endorsement, certification, verification, or letter of good standing fee
28 is ~~thirty~~ one hundred dollars ~~(\$30)~~ (\$100).

29 (i) The letter of good standing fee or for loan deferment is
30 ~~thirty~~ one hundred dollars ~~(\$30)~~ (\$100).

31 (j) There shall be a fee of ~~sixty~~ one hundred dollars ~~(\$60)~~ (\$100) for the
32 issuance and renewal of a resident's license under Section 2475.

33 ~~(k) The application fee for ankle certification under Section 2472~~
34 ~~for persons licensed prior to January 1, 1984, shall be fifty~~
35 ~~dollars (\$50). The examination and reexamination fee for this~~
36 ~~certification shall be seven hundred dollars (\$700).~~

37 (l) The filing fee to appeal the failure of an oral examination
38 shall be ~~twenty five~~ one hundred dollars ~~(\$25)~~ (\$100).

39 (m) The fee for approval of a continuing education course or
40 program shall be ~~one~~ two hundred ~~fifty~~ dollars ~~(\$100)~~ (\$250).

41
42
43 2499.6. The fees in this article shall be fixed by the board in
44 accordance with Section 313.1.

45
46
47 2499.8. Any licensee who demonstrates to the satisfaction of the
48 board that he or she is unable to practice podiatric medicine due to
49 a disability may request a waiver of the license renewal fee. The
50 granting of a waiver shall be at the discretion of the board and may
51 be terminated at any time. Waivers shall be based on the inability of
52 a licensee to practice podiatric medicine. A licensee whose renewal
53 fee has been waived pursuant to this section shall not engage in the
54 practice of podiatric medicine unless and until the licensee pays the
55 current renewal fee and does either of the following:

56 (a) Establishes to the satisfaction of the board, on a form
57 prescribed by the board and signed under penalty of perjury, that the
58 licensee's disability either no longer exists or does not affect his
59 or her ability to practice podiatric medicine safely.

1 (b) Signs an agreement on a form prescribed by the board, signed
2 under penalty of perjury, in which the licensee agrees to limit his
3 or her practice in the manner prescribed by the reviewing physician.
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58 G. DCA quarterly and annual performance measure reports.
59 Attached

DRAFT

Performance Measures

Q1 Report (July - Sept 2010)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement.

These measures will be posted publicly on a quarterly basis. In future reports, additional measures, such as consumer satisfaction and complaint efficiency, will also be added. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints received.*

Q1 Total: 17 (Complaints: 14 Convictions: 3)

Q1 Monthly Average: 6

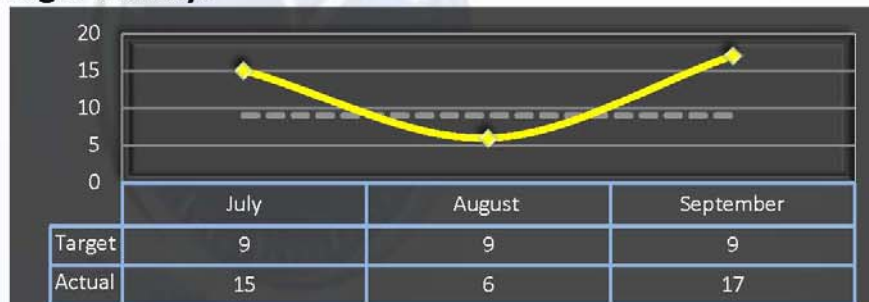


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q1 Average: 15 Days



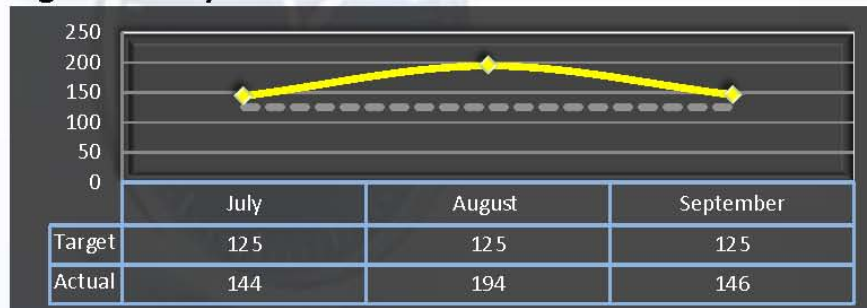
*"Complaints" in these measures include complaints, convictions, and arrest reports.

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q1 Average: 159 Days



Formal Discipline

Average cycle time from complaint receipt to closure, for cases sent to the Attorney General or other forms of formal discipline.

Target: 540 Days

Q1 Average: 378 Days (only 1 data point available)



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q1 Average: N/A

The Board did not report any probation monitoring data this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 14 Days

Q1 Average: N/A

The Board did not report any probation violation data this quarter.

Performance Measures

Q2 Report (October - December 2010)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q2 Total: 22

Complaints: 21 Convictions: 1

Q2 Monthly Average: 7

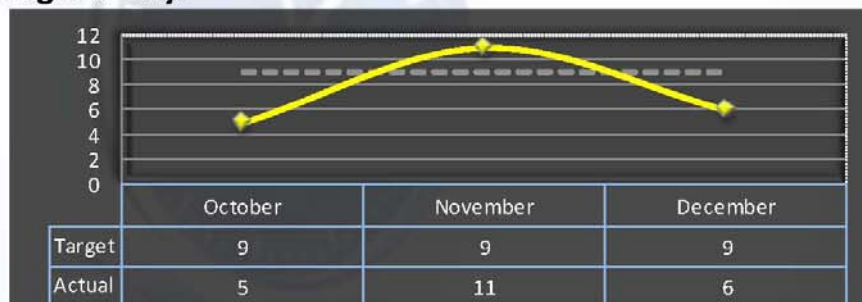


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q2 Average: 7 Days

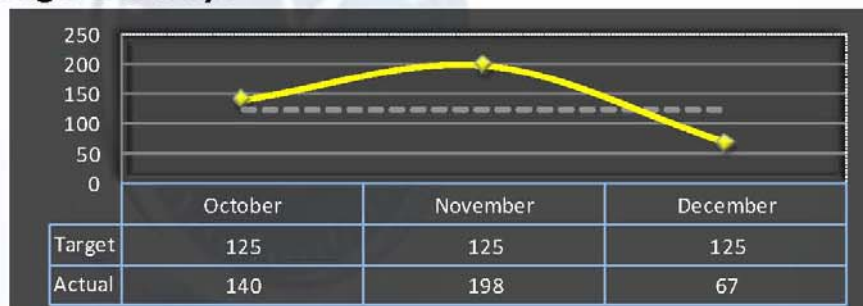


Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q2 Average: 145 Days

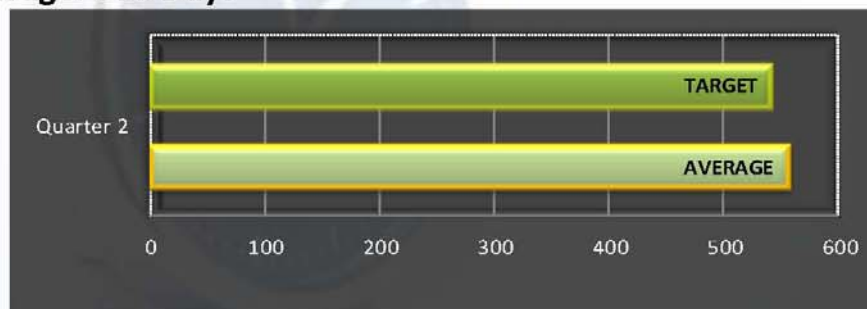


Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 540 Days

Q2 Average: 555 Days

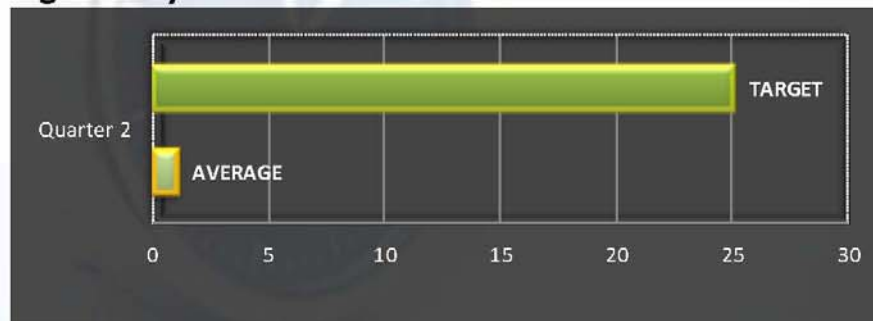


Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q2 Average: 1 Day



Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 14 Days

Q2 Average: N/A

The Board did not handle any probation violations this quarter.

Performance Measures

Q3 Report (January - March 2011)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

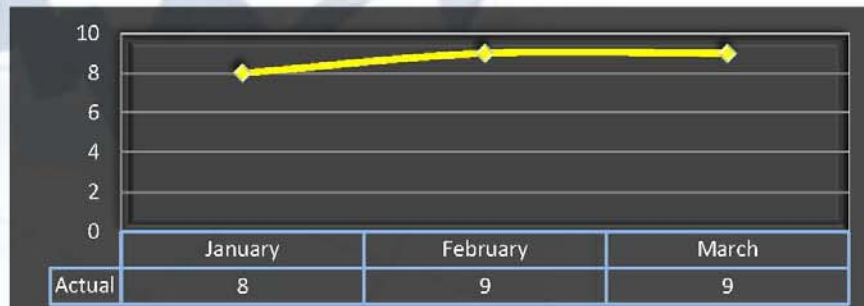
In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q3 Total: 26

Q3 Monthly Average: 9

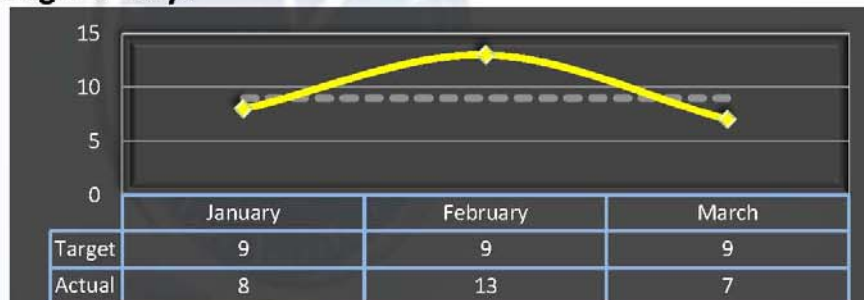


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q3 Average: 9 Days

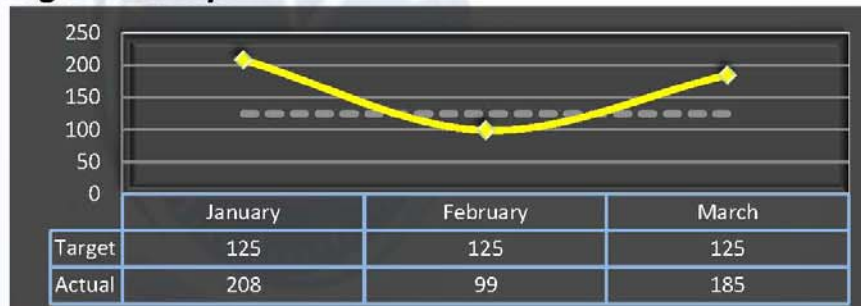


Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q3 Average: 174 Days



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 540 Days

Q3 Average: N/A

The Board did not close any formal discipline cases this quarter.

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q3 Average: N/A

The Board did not contact any new probationers this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 14 Days

Q3 Average: N/A

The Board did not handle any probation violations this quarter.

Performance Measures

Q4 Report (April - June 2011)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q4 Total: 23

Q4 Monthly Average: 8

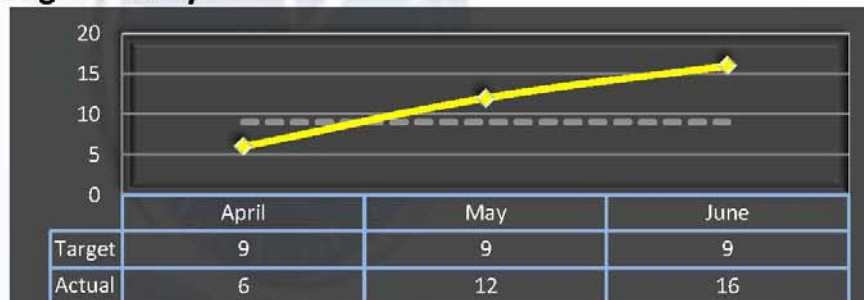


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q4 Average: 11 Days

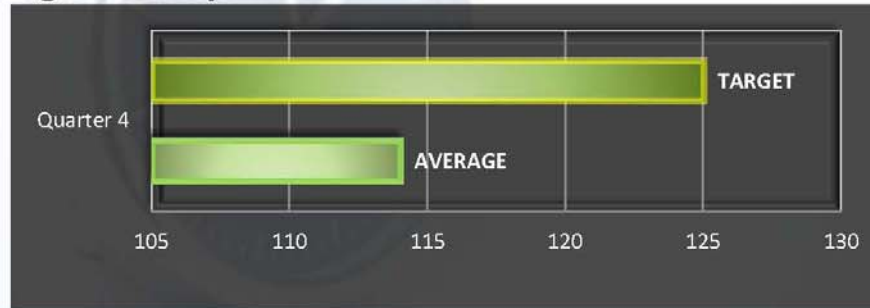


Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q4 Average: 114 Days



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 540 Days

Q4 Average: 1,046 Days



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q4 Average: N/A

The Board did not contact any new probationers this quarter.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 14 Days

Q4 Average: N/A

The Board did not handle any probation violations this quarter.

Performance Measures

Annual Report (2010 – 2011 Fiscal Year)

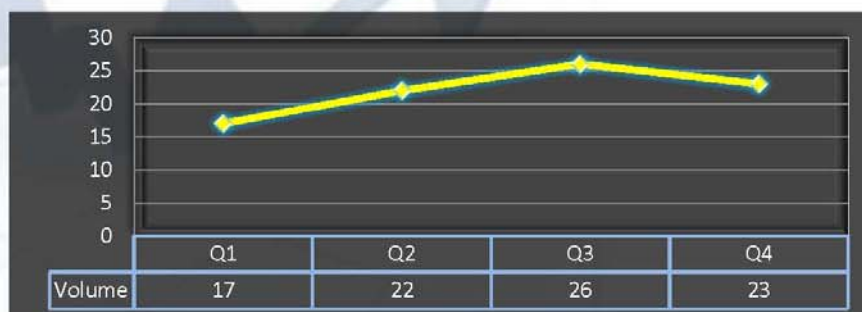
To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the first four quarters worth of data.

Volume

Number of complaints and convictions received.

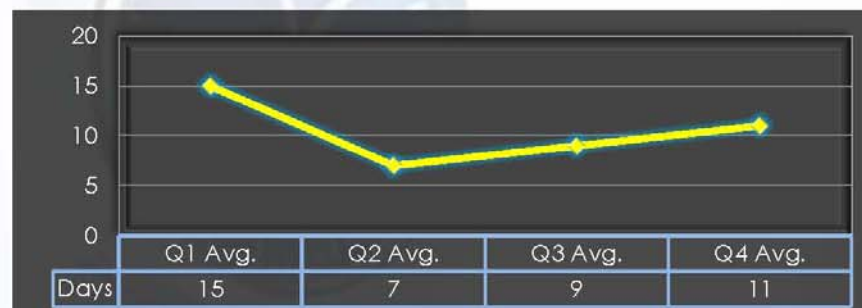
The Board had an annual total of 88 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

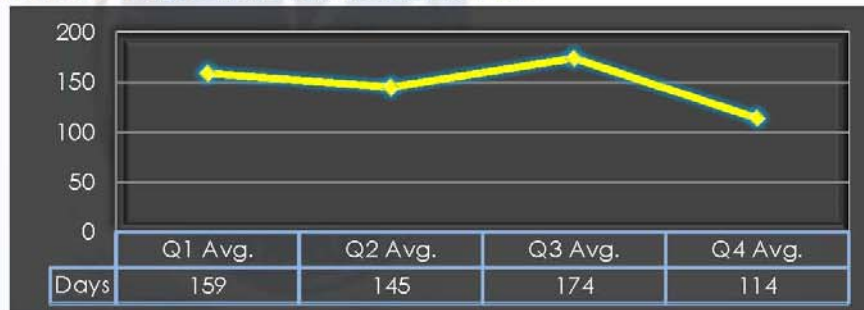
The Board has set a target of 9 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

The Board has set a target of 125 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

The Board has set a target of 540 days for this measure.



Exhibit R

Calendar for year 2012 (United States)

January						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29			

March						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

June						
Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

July						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

August						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

September						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

October						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

November						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

December						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Holidays and Observances:

Jan 1 New Year's Day	May 13 Mother's Day	Nov 6 Election Day
Jan 2 'New Year's Day' observed	May 28 Memorial Day	Nov 11 Veterans Day
Jan 16 Martin Luther King Day	Jun 17 Father's Day	Nov 12 'Veterans Day' observed
Feb 14 Valentine's Day	Jul 4 Independence Day	Nov 22 Thanksgiving Day
Feb 20 Presidents' Day	Sep 3 Labor Day	Dec 9 First Day of Chanukah
Apr 6 Good Friday (Many regions)	Sep 17 Rosh Hashana	Dec 16 Last day of Chanukah
Apr 7 First day of Passover	Sep 26 Yom Kippur	Dec 24 Christmas Eve
Apr 8 Easter Sunday	Oct 7 Last day of Sukkot	Dec 25 Christmas Day
Apr 9 Easter Monday	Oct 8 Columbus Day (Most regions)	
Apr 14 Last day of Passover	Oct 31 Halloween	

Calendar generated on www.timeanddate.com/calendar